

VETERANS' ADMINISTRATION MEDICAL FACILITIES CONSTRUCTION

HEARING BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE OF THE COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES NINETY-SEVENTH CONGRESS SECOND SESSION

APRIL 1, 1982

Printed for the use of the Committee on Veterans' Affairs

Ser. 97-61



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON: 1982

97-103 O

H761-35

COMMITTEE ON VETERANS' AFFAIRS

G. V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
JACK BRINKLEY, Georgia
RONALD M. MOTT, Ohio
BOB EDGAR, Pennsylvania
SAM B. HALL, Jr., Texas
DOUGLAS APPELEGATE, Ohio
MARVIN LEATH, Texas
WILLIAM HILL BONER, Tennessee
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
BOB STUMP, Arizona
PHIL GRAMM, Texas
AUSTIN J. MURPHY, Pennsylvania
BYRON L. DORGAN, North Dakota
ANTONIO WON PAT, Guam

JOHN PAUL HAMMERSCHMIDT, Arkansas
MARGARET M. HECKLER, Massachusetts
CHALMERS P. WYLIE, Ohio
ELWOOD H. HILLIS, Indiana
HAROLD S. SAWYER, Michigan
GERALD B. H. SOLOMON, New York
JIM JEFFRIES, Kansas
BOB McEWEN, Ohio
JIM DUNN, Michigan
CHRISTOPHER H. SMITH, New Jersey
ALBERT LEE SMITH, Jr., Alabama
DENNY SMITH, Oregon
MARK D. SILJANDER, Michigan
JAMES L. NELLIGAN, Pennsylvania

MACK FLEMING, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

RONALD M. MOTT, Ohio, *Chairman*

DON EDWARDS, California
DOUGLAS APPELEGATE, Ohio
WILLIAM HILL BONER, Tennessee
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
PHIL GRAMM, Texas
BOB EDGAR, Pennsylvania
BYRON L. DORGAN, North Dakota

JOHN PAUL HAMMERSCHMIDT, Arkansas
MARGARET M. HECKLER, Massachusetts
ELWOOD H. HILLIS, Indiana
GERALD B. H. SOLOMON, New York
BOB McEWEN, Ohio
JIM DUNN, Michigan
CHRISTOPHER H. SMITH, New Jersey
ALBERT LEE SMITH, Jr., Alabama

CONTENTS

APRIL 1, 1982

VA Medical Facilities Construction	Page 1
--	-----------

STATEMENTS BY COMMITTEE MEMBERS

Chairman Mottl.....	1
Hon. John Paul Hammerschmidt.....	2

WITNESSES

Vento, Hon. Bruce, a Representative in Congress from the State of Minnesota	3
Prepared statement of Congressman Vento.....	63
Gonzalez, Hon. Henry, a Representative in Congress from the State of Texas...	5
Prepared statement of Congressman Gonzalez	64
Frenzel, Hon. Bill, a Representative from the State of Minnesota	7
Prepared statement of Congressman Frenzel	65
Sabo, Hon. Martin, a Representative in Congress from the State of Minnesota.	8
Prepared statement of Congressman Sabo.....	67
Hagedorn, Hon. Tom, a Representative in Congress from the State of Minnesota.....	9
Prepared statement of Congressman Hagedorn.....	68
Erdahl, Hon. Arlen, a Representative in Congress from the State of Minnesota.....	11
Prepared statement of Congressman Erdahl.....	69
Nimmo, Hon. Robert, Administrator, Veterans' Administration.....	17
Prepared statement of Mr. Nimmo.....	71
Mansfield, Gordon H., associate legislative director, Paralyzed Veterans of America.....	55
Prepared statement of Mr. Mansfield	105
Lyngh, Robert E., director, National Veterans Affairs and Rehabilitation Commission, The American Legion.....	55
Prepared statement of Mr. Lyngh	108
Heilman, John F., national legislative director, Disabled American Veterans...	58
Prepared statement of Mr. Heilman	112
Schwab, Donald H., director, Veterans of Foreign Wars of the United States....	60
Prepared statement of Mr. Schwab	114
Brinsky, Gabriel P., AMVETS National Service and Legislative Director	61
Prepared statement of Mr. Brinsky	118

MATERIAL SUBMITTED FOR THE RECORD

Articles:	
Excerpts for HUD/Independent Agencies Subcommittee hearing of March 9, 1982.....	100
Letters:	
To Administrator Nimmo from 14 Members of Congress, expressing their concern about the fate of the Minneapolis VA Hospital	67
To Chairman Mottl from VA General Counsel John P. Murphy, re curtailment of outpatient services at the Miami VA Medical Center for certain veterans	73
To Congressman Bill Frenzel from VA Administrator Nimmo re Minneapolis VA Medical Center.....	74

IV

Letters—Continued	Page
To Mack Fleming, chief counsel and staff director, House Committee on Veterans' Affairs, from William F. Sullivan, VA Associate Deputy Administrator for Logistics re VA Facility Planning and Construction Committee (FPACC).....	78
To Hon. Bob Edgar, from VA Administrator Nimmo, re alternatives for providing outpatient services to the veterans of northwest Indiana.....	79
Projects:	
VA major revalidation projects for fiscal year 1984.....	75
New criteria for revalidation of the VA medical facility construction program	77
Reports:	
The American Legion visitation report of VA Medical Center, Philadelphia, Pa	80
Study:	
Feasibility of providing alternative outpatient services to veterans residing in northwest Indiana	146
Written committee questions and their response:	
Chairman Mottl to VA Administrator Nimmo	122
Hon. John Paul Hammerschmidt to VA Administrator Nimmo.....	139
Hon. Bob Edgar to VA Administrator Nimmo.....	145

VETERANS' ADMINISTRATION'S MEDICAL FACILITIES CONSTRUCTION PROGRAM

THURSDAY, APRIL 1, 1982

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Members present: Representatives Dunn, McEwen, A. Smith, Heckler, Hammerschmidt, Mottl, Applegate, Mica, Dorgan, Daschle, and Edgar.

OPENING STATEMENT OF CHAIRMAN MOTTL

Mr. MOTTL. Good morning. The Subcommittee on Hospitals and Health Care will come to order.

This morning we are conducting an oversight hearing on the Veterans' Administration's medical facilities construction program and the major construction projects included in the fiscal year 1983 budget requests.

The testimony we will hear today will assist us in developing the construction and leasing resolution we are required to submit under section 5004(a) of title 38, United States Code.

We also want to learn more about the Administrator's plans, as reported in the media, to revalidate a reported \$2.7 billion worth of medical facility construction. As I understand his news release and his statements before the full committee on March 1, 1982, Mr. Nimmo is developing criteria for medical facility construction that will permit him to accurately prioritize the projects in order of need and urgency. I would add that the law has required precisely that since the enactment in 1979.

Needless to say, the replacement hospital at Minneapolis, Minn., will be extensively discussed this morning. In the news release I have mentioned, the Administrator specifically pointed to the replacement of the VA medical center in Minneapolis as an example of a project which was ill-conceived.

He based his belief principally on the existence of 2,000 empty or underutilized beds in the community. The Congress debated this issue in July 1980, when it considered the HUD-Independent Agencies appropriations bill for fiscal year 1981.

You may recall that a local health systems agency was opposed to the bed sizing of the proposed replacement VA medical center,

due to the excess beds in the private sector in the Minneapolis area.

After this debate, the Congress adopted the Hagedorn-Roberts amendment, which in effect said that the catchment area of the Minneapolis VA medical facility was much larger than the metropolitan area, and no local health systems agencies would dictate bed sizing of a Federal hospital.

In light of this congressional mandate, I was surprised to read of Mr. Nimmo's objections to the replacement of the Minneapolis VA Hospital because of the 2,000 empty beds in the private sector.

We also note the omission of the construction funds in the fiscal year 1983 budget request. We find this particularly puzzling as the 5-year medical facilities construction plan has shown it as the facility most in need of replacement for at least the last 2 years.

Before we call our first witness this morning, I would like to recognize the distinguished ranking minority member, John Paul Hammerschmidt, for any opening remarks he would care to make.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I look forward to the testimony this morning. The VA's proposed major construction program for 1983 involves about \$450 million. It is a program that is most difficult to administer because of inflation pressures, changes in the state of the art with respect to hospital construction, and changes in scope brought about by changing medical needs.

On occasion, there have also been imprecise estimates on construction costs, and I am sure some faulty planning. These cause painful reprogramming of funds and requests for additional appropriations. If you add to all these matters explainable delays in construction schedules caused by difficulties in architect-engineer selection, the time element of acquiring sites and those delays caused by such things as weather conditions, strikes and deliveries of supplies and equipment, it can readily be seen that this is a program that requires great expertise in terms of its management.

I have visited a number of new VA hospitals and I have been tremendously impressed by them. I think that generally the VA has done a pretty good job under difficult circumstances. The new VA hospital in Little Rock is a proud addition to the VA system. It would be helpful to me if the Administrator could update us this morning on that facility and the other ones that are now under construction.

Mr. Chairman, I understand that Mr. Nimmo will clarify in his testimony this morning some recent statements attributed to him. These statements concern the Minneapolis construction project, to which you have referred, the construction costs of affiliations with medical schools, and a need to review all 1984 and beyond construction plans.

With respect to the latter, let me say that I applaud any good review of matters affecting expenditures of public funds, and in this connection, I think the Administrator is just being prudent and doing his job. I would hope and expect that his review will be

thorough and that it will be expedited, and that thereafter we will all be reassured that this committee is authorizing and approving only those major construction projects that are meeting the basic test of need and priority.

Thank you, Mr. Chairman.

Mr. MORRIS. Thank you very much, Mr. Hammerschmidt, for your excellent statement.

This morning we have an extensive list of witnesses. In addition to the Administrator of the veterans' affairs of the national veterans' organizations, we have six distinguished Members of the House who will present testimony concerning the VA medical construction program in their areas.

Is Mr. Gonzalez here?

If not, let's get the contingent from the Minnesota area, if they would be kind enough to come to the front table together. I see Mr. Frenzel and Mr. Vento. Anybody else from the Minneapolis area? Mr. Hagedorn, Mr. Sabo, Mr. Erdahl.

It is with a great deal of pleasure that I welcome here two of this esteemed delegation from Minnesota. The gentleman, Bruce Vento, was one of the leaders in that amendment fight on the floor with Mr. Hagedorn and Mr. Frenzel and Mr. Roberts. They were very successful in persuading the House of Representatives as to the need for the additional beds at the Minneapolis hospital. You are certainly to be congratulated for your fight at that time.

So we certainly welcome you. Are you going to speak first, Mr. Vento? Whoever it is agreed upon, either Mr. Frenzel or Mr. Vento. Both are distinguished colleagues that we want to welcome here this morning.

STATEMENT OF HON. BRUCE VENTO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. VENTO. Mr. Chairman, my senior colleague has permitted me the privilege of going first, which I appreciate, because we have been working on a bipartisan basis for some time.

And we appreciate the support we received from the veterans' committee in that instance of the floor fight on the size of this hospital and health care planning needs in our area. It has been a laborious process, one in which we felt that we had gone along in the best tradition.

This committee has provided a good process for health care planning and for determination of needs. That's why today we are very concerned about the seeming departure and rather arbitrary decisionmaking with regard to meeting those particular veterans health care needs.

I want to first of all thank you, of course, and the other Members. On March 1, when I asked for this particular hearing we hoped that we could deliberate and find out what the concerns are, and then move ahead with this hospital. I appreciate the support that I have received from other members of my delegation with regards to this particular fight.

The need for a replacement VA hospital is well documented, Mr. Chairman. Both the VA and the Twin Cities Metropolitan Health Board have studied this project. Both have recognized the inade-

quacy of the present outmoded facility. Congress authorized and appropriated \$15 million in planning and site preparation funds for this project in fiscal year 1981.

We are now asking the subcommittee, and the Congress as a whole, to proceed as scheduled by authorizing an appropriation of construction funds for the Minneapolis VA Hospital in the fiscal year 1983 budget.

The Reagan administration and VA Administrator Nimmo are apparently anxious to backtrack on the VA commitment to upper Midwest veterans. The administration has not included in their fiscal year 1983 budget request the necessary \$206.4 million in construction funds slated for the Minneapolis VA Hospital.

In my opinion, this decision is both irresponsible and economically unsound.

Mr. Chairman and members, to be brief, if we do not fund the hospital this year, we are likely to experience about 11-percent increase a year. That would mean, if this is delayed 1 year, the original cost of this \$221 million facility would increase about \$23 million the first year. That's the type of problem that we face in meeting this need.

I am greatly disturbed by the specific comments of the VA Administrator, who singled out the Minneapolis project as having problems. I wonder what the criteria are for that. It certainly stands as a negative signal to those of us in Minnesota who have waited so long.

Mr. Chairman, I wish I could take you and the members of this subcommittee on a tour of the Minneapolis VA Hospital facility. It is made up of a series of different, antiquated buildings. The newest building, built in the 1950's, is sort of a highrise, ward-type of veterans' hospital. I think it epitomizes, probably, the wrong direction in terms of what we need in health care facilities in this Nation. And obviously it doesn't offer personal or good accommodations for veterans.

Parts of this facility are over 100 years old. Quonset huts fill the need for a pharmacy. It is a campus type of arrangement. It might look like Shangri-la, Mr. Chairman and members, but it is far from that in terms of meeting health care needs.

It is inefficient, it is inadequate, and it does a disservice to the type of health care system that we have for veterans. We would be well served, indeed, by moving ahead with this proposed new facility.

Many have suggested alternatives with regards to remodeling or renovating this particular facility. It simply isn't possible. Study upon study has occurred. The review process sort of reminds me of the dog chasing its tail type of syndrome. No one wants to construct something that isn't necessary, but clearly this area, Medical District 18, that is served by it, a five-State area, needs an adequate facility to meet the commitments that we have made to veterans in previous years.

We are asking you to uphold the priority of project status that this particular facility had, and to move ahead. We are very concerned about reshuffling priorities. We have waited long, and we hope that we will win your support here today. We look forward to

cooperating with you and hope we will have your support, Mr. Chairman and members.

[The prepared statement of Congressman Vento appears on p. 63.]

Mr. MORTL. Thank you very much, Mr. Vento, for your excellent statement.

Mr. Frenzel, if we could, before I recognize you, hear from Mr. Gonzalez. He has a subcommittee chairmanship that he has to take over the duties of, and if we could rest from Minneapolis for a moment and get to Mr. Gonzalez.

Henry, the subcommittee would like to welcome you here this morning. You are an excellent Congressman, and we look forward to your statement.

STATEMENT OF HON. HENRY GONZALEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GONZALEZ. Thank you very much, Mr. Chairman. I am deeply grateful, and I appreciate my colleagues here appearing. It is true, we have a subcommittee. In fact, Mr. Vento is one of the most illustrious members of that subcommittee.

But in order to also reciprocate in kind, I will be very brief, and I will ask unanimous consent that the statement I have submitted in advance to the subcommittee be entered into the record intact.

Mr. MORTL. Without objection, it will so be entered.¹

Mr. GONZALEZ. And then I will try to summarize.

I am deeply grateful for the invitation you extended, Mr. Chairman. I can't tell you in words how grateful I am. The administration's budget for 1983 includes funding for the 120-bed nursing unit at the Audie Murphy VA Hospital in San Antonio.

This is something that I initiated a few years ago, when there was some resistance to the idea, but only after the impelling need came up from the VA population, the veterans, and particularly our newer veterans, amazingly.

All I asked the VA originally, and this was more than 3 years ago, was that they look into the matter. When they did, they found that it was justified, and it was approved. Then the local review, since this is a procedure that has been followed, the so-called local council of governments, had an advisory group.

The only negative came from two members of that group. That surprised the director of the local VA hospital, but examination reveals that both of them are persons who have a conflict of interest. They are substantial owners of private nursing homes in San Antonio. So that's the only negative that we've had.

However, even the present administration, upon review, found, too, that it is legitimate and necessary, and they have approved it. As I said, and I repeat, it is included in the budget recommendations.

There are quite a number of veterans in our area. This is the reason that when I first came up 20 years ago, a hospital was a priority project. The veteran population, which at that time exceeded any other area in Texas for need of a veterans' hospital—before that, a veteran in our area, which is the large geographical area of

¹ The prepared statement of Congressman Gonzalez appears on p. 64.

southwest Texas, would have to go either to the Houston or Dalias area.

We had a small hospital north of San Antonio, about 80 miles away, at Kerrville. But it was so limited and so small that it was inconsequential.

I impelled a movement that finally received President Kennedy's personal attention. He announced his decision in 1963 for what is now the Audie Murphy Hospital. In fact, the name "Audie Murphy" was something that I suggested to then-Chairman Tiger Teague. Mr. Murphy was a constituent of his.

But actually I had envisioned the naming of the hospital after a Congressional Medal of Honor winner of Mexican descent from Texas. We compromised, and I offered the alternative suggestion, because Audie Murphy would be the first noncom after whom anything was named, including a VA hospital.

So there's a lot of history here, and I am so identified with the hospital from its very beginning that I can't tell you in words how grateful I have been to this committee.

There is no question in my mind that the need for this nursing home facility is very dire. San Antonio does not have an excess of nursing homes. And it dovetails perfectly with the plans that the VA hospital has, because the same medical care that is afforded the veterans who will be the logical users of the nursing home care will continue that, because the plans call for that kind of an overall delivery of medical care and service and nursing home care.

In conclusion, I again thank the committee and you, Mr. Chairman, for your generosity and the opportunity to be here. I hope that you will uphold the recommendation as envisioned in the budget.

Mr. MOTT. Thank you very much, Mr. Gonzalez, for your excellent statement. It will go a long way to help your project, I'm sure. As usual, you have done a fine job, and it was a pleasure having you here this morning. I know you have to get back to your subcommittee.

Mr. GONZALEZ. Yes, sir, I regret very much, but if you will excuse me, I will go back, because it is one that I'm sharing, and we're expecting to have the Secretary of HUD.

Thank you again for your consideration. Thank you, Mr. Vento.

Mr. HAMMERSCHMIDT. Mr. Chairman, may I also add my word of thanks to Henry Gonzalez for being before our committee. It appears to me that, of course, that's an excellent project, and it also appears to me that it is well on track. But your appearance here certainly enhances it.

Mr. GONZALEZ. Thank you very much.

Mr. HAMMERSCHMIDT. It looks like it's very much needed.

Thank you, Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much.

Mr. MOTT. Now let's get back to Minneapolis, Minn., and their project.

We'd like to recognize, in the order of appearance here, Mr. Frenzel. Not only is he an outstanding Congressman, Mr. Hammerschmidt, but he's a great baseball catcher for the Republican team. He does a good job on behalf of this project.

Bill, your entire statement will be submitted into the record, without objection. You may summarize or proceed as you deem fit.

STATEMENT OF HON. BILL FRENZEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. FRENZEL. Thank you very much, Mr. Chairman. We are all grateful for the opportunity to appear before you, and we are grateful to the subcommittee for holding hearings.

We in Minnesota and in the five-State area served by the Minneapolis VA Hospital have been enormously concerned by the administration's proposed deferment or maybe derailment of a project for which we have waited for many, many years.

Mr. Vento described some of the difficulties in the current hospital. It is a chopped-up series of buildings which have been built over a long period of years. It has dead-end corridors and narrow staircases which now do not conform to the fire and safety codes of the area but, because we were supposed to get a new building, those codes have not been very strictly enforced.

We have difficulties putting gases into the operating rooms. They have to be wheeled in on a portable cart. We don't have any waiting room. We have 16-bed wards which, I think, are not very good procedure in this day and age.

For all of these reasons, the Minneapolis hospital has headed the VA's list of hospitals in need of replacement. Design money of \$15 million was approved in 1981. Another \$265 million was supposed to be in the fiscal year 1983 budget. But it wasn't there this year, as you well recall.

On February 18 all 12 Representatives from the affected area wrote to Mr. Nimmo, the Administrator, asking why he removed the Minneapolis hospital from the priority list. You have a copy of that letter, Mr. Chairman, but I have also attached it to my testimony.¹

We have not had a reply to our letter, and we are still, of course, anxiously waiting. I think what bothered us most about Mr. Nimmo's testimony before your committee was that he gave strange answers to questions about what happened to that hospital on the priority list, first indicating that Congress had taken it off.

You, of course, know very well that that's not the case. Then one of his aides indicated that the list was not a matter of priority. It just was a random list of hospitals. But we note that section 5007 of title 38 provides that the list will be in order of priority.

Mr. Sullivan, who testified at the same time, then stated that Minneapolis was not included in the 1983 budget because its design phase had not yet been completed. That was a true statement, but it wasn't a complete statement. We are in our present position largely because of bureaucratic bungling in Washington. VA administration here held up that contract for 9 months, while they fiddled around trying to figure out what to do with the architect, and looked for a cheaper rate and got a more expensive one, I understand.

¹See p. 67.

But it is misleading, I think, to say that Minneapolis won't be ready for this money in 1983. That's not a good reason to keep it out of the budget. Working drawings will be completed by June of 1983, before the end of the fiscal year. And I am informed that the VA can award a construction contract even before the working drawings are completed.

There have been some other delays, of which this subcommittee is well aware. But now we get the impression that the VA is trying to postpone construction of this building and talk about renovation.

Mr. Chairman, we've been renovating these buildings since the 1920's. In 1979 the Office of VA Construction and Estimating Services reported that a replacement hospital would only cost a million more dollars—that's out of \$280 million—than renovation of the old buildings to put them in modern condition. And I submit that that's a pretty poor tradeoff, because when you get done renovating, what you have is an old building that you have to renovate some more every year.

Now we think that this situation has been studied up and down and back and forth and crosswise, until all the people involved are black and blue with study. We don't need any more studies. This thing was first on the priority list. It still ought to be first on the priority list.

I thank the subcommittee for giving me this chance to testify. Veterans of the five States that are served by this hospital hope that Mr. Nimmo will be able to address some of these concerns when he testifies again before you.

I forgot to indicate, Mr. Chairman, that three members of our delegation are not here, but they have indicated their strong support for this hospital, as have Senators in the affected area.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Frenzel appears on p. 65.]

Mr. MORTL. Thank you very much, Mr. Frenzel. As usual, you do excellent work, especially on behalf of this project.

Next the Chair will recognize Mr. Martin Sabo, the gentleman from Minnesota, who is also an outstanding athlete in basketball and baseball, and does a great job as a Congressman.

Welcome here this morning. Your entire statement will be submitted into the record. You may proceed as you think fit.

STATEMENT OF HON. MARTIN SABO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. SABO. Thank you, Mr. Chairman and members of the subcommittee. I appreciate the opportunity to be here this morning.

As you all know, the Minneapolis Veterans' Administration Medical Center has been No. 1 on the construction priority list of the VA for several years.

After extensive review by both the local VA Administrator and the Congress, this committee authorized, and the Appropriations Committee appropriated planning funds for this hospital.

These funds were appropriated in 1981, with the clear understanding that construction would begin in 1983. The administration has seen fit, however, to delete funding for this project from the 1983 budget.

Upon questioning in the HUD Subcommittee of Appropriations, Mr. Nimmo informed me that he felt the need to revalidate this project, along with most other VA construction projects.

Mr. Chairman, and members of the subcommittee, this project has been studied and validated to death. This hospital is old and outmoded. No one has quarreled with the fact that something needs to be done with it. Even Mr. Nimmo concedes that fact.

The Ellerbe firm, a nationally prominent architectural firm which specializes in hospital design made extensive studies of Minneapolis hospitals. Based on their work, both the local VA administration in Minneapolis and the Central VA Office in Washington, concluded that replacement of the hospital was more cost effective than renovation.

Mr. Cooney, the Minneapolis hospital administrator, and his staff informed me that this VA hospital has been designed from the local level up. The administrator and his staff have spent untold hours working with the architects on plans for the new hospital. They have a very good relationship with the architects and they tell me the plans are moving along on schedule. VA officials have also testified before the HUD Subcommittee of Appropriations that they would be able to begin construction of the Minneapolis hospital if funds were available in 1983.

As you know, the construction season in Minnesota is very short. Sometimes a 1-month delay can set a project back a whole year.

Mr. Chairman, as you know, the 1983 budget is currently in a state of great disarray. I do not know if it will be possible to find the funds necessary to begin construction on this hospital or not. However, I would urge you to authorize the hospital so that if we can find the funds in the budget process, appropriations can be made and the project can move ahead as planned.

Mr. Chairman, I also have available for your staff and the members of the subcommittee, probably not for the record, however, because it's rather long, a copy of testimony before the HUD Subcommittee of Appropriations on the Minneapolis hospital and I will leave that for you.

[The prepared statement of Mr. Sabo appears on p. 67.]

Mr. MORTL. Thank you very much. We appreciate you leaving that. The subcommittee did an excellent job and we appreciate your efforts this morning on behalf of the hospital in Minneapolis.

Next we will hear from the gentleman from Minnesota, Tom Hagedorn, who was most instrumental in that amendment. He was the prime sponsor of that amendment, along with Mr. Roberts who was chairman of the full committee at that time, and Tom, you did a great job on the floor, and we look forward to your testimony here this morning.

Your entire statement will be submitted to the record, and you may proceed as you see fit.

STATEMENT OF HON. TOM HAGEDORN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. HAGEDORN. Thank you very much, Mr. Chairman.

When we took it up on the floor, we thought we had pretty much taken care of this issue.

I want to thank your subcommittee and yourself, Mr. Chairman, for giving us the opportunity to testify today on behalf of a project of vital importance, not only to the veterans of Minnesota and surrounding States, but to all the Nation's veterans who are or will be in need of medical care.

In particular, I would like to express my appreciation to you, Mr. Chairman, for your help in keeping members informed of developments with regard to the Minneapolis project.

While I am pleased to speak on behalf of the planned replacement hospital for the veterans in Minneapolis once again, I am somewhat concerned that my colleagues in the delegation and I must come today prepared not only to support the new hospital, but to defend its viability. I am dismayed that the need for this new facility is being questioned from within the VA itself.

In the interest of time I am only going to discuss the issue of bed size in my remarks before you today and submit my full testimony to be included in the permanent record.

I am greatly concerned by comments of VA Administrator Bob Nimmo published in a Texas newspaper which you were so kind to bring to my attention, Mr. Chairman. And in this article Mr. Nimmo questioned the sense of replacing the VA hospital in Minneapolis when he contends that there are 2,000 empty beds in private hospitals in that city.

Now, there was a study in 1977 that did show that there were as many as 2,000 surplus beds in the metropolitan area. Since that time two hospitals have been closed, and the latest surplus figures show that there are less than 200 beds in that area.

Now, if Mr. Nimmo can support his reckless accusations, then I'd like to respectfully suggest that he at least answer the letters that my colleagues and I have sent to him for his reasoning regarding this matter.

Two years ago the proposed number of beds in this new facility was an issue of some controversy in the House. At that time, the local metropolitan health board recommended that the size of the facility be restricted to 649 beds rather than the 845-bed level approved by the VA and supported by this congressional Veterans' Committee, OMB and all the veterans groups. The reason for the proposed reduction was an alleged surplus of hospital beds in the metropolitan area.

The House Appropriations Committee attempted to implement this restriction through language in the HUD-Independent Agencies fiscal year 1981 appropriations bill. An amendment I offered to stop this effort to restore funding for the 845-bed facility was successful. The House clearly expressed its approval of these plans by an overwhelming vote on the House floor.

Several points were made at that time regarding local bed surpluses and the mission of the VA hospitals, which I believe are quite relevant in view of some of Mr. Nimmo's comments. As you know, the Minneapolis hospital is a regional facility, serving veterans in a 5-State area and beyond, and it is part of a national system which provides care to the country's 30 million veterans.

A much needed facility like the Minneapolis VA Medical Center cannot be compromised in an effort to remedy the local problem of overconstruction of hospital beds. The VA's mission is to serve vet-

erans, not to solve the shortsighted problems of our local health planners.

Furthermore, empty beds in private hospitals do not fulfill the need of veterans for medical care. The mission of the VA medical care system is unlike that of private hospitals, whose interest in the patient is limited to the particular medical problem at hand and ceases at discharge. The VA, on the other hand, provides a continuation of care to veterans, which extends to their general physical and economic well-being and does not simply end at discharge. It goes far beyond a 2-week occupancy of a hospital bed.

To suggest that any bed in any hospital is good enough for any veteran injured in service to the Nation is, I believe, a great disservice to these men and women.

I might also mention that the proposals for a voucher system of providing medical care to veterans have never been supported by evidence that this would be less expensive to our Government.

In conclusion, I want to reiterate my strongest support for the earliest possible funding for construction of a new Minneapolis hospital. The need for this VA facility has been proven beyond all doubt, and I see no evidence to justify further delay.

The veterans who rely, or who will be relying, on the Minneapolis hospital for medical care deserve better than the feet dragging and ambiguity that they have had to endure so far.

I congratulate this subcommittee for keeping a responsive and responsible watch over the VA medical care system, and I am confident that you will see that the medical needs of veterans continue to be met in the years to come.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hagedorn appears on p. 68.]

Mr. MORTL. Thank you very much, Tom, for your excellent statement. We appreciate all your efforts. You've done a great job.

Last but not least is our distinguished colleague from Minnesota, Arlen Erdahl. It's a pleasure to have you here with us this morning, Arlen, and your entire statement will be submitted into the record without objection.

STATEMENT OF HON. ARLEN ERDAHL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. ERDAHL. Thank you very much, Mr. Chairman.

It is a pleasure for me to be here to address you and your colleagues. I guess I could just shorten it down by just saying amen, because I endorse what my colleagues have said, and obviously we have a unanimous bipartisan support for moving ahead on this issue.

I will briefly pick out a couple of paragraphs of my remarks, because some of it obviously touches on things that my colleagues have already said.

But it certainly does seem unfortunate that here today the Congress would have to address itself, and you have to specifically address yourself, the subcommittee, to the matter of the VA hospital construction in Minneapolis. Just 2 short years ago, Congress decided that a new veterans' hospital in the Twin Cities was needed to serve the veterans in the Midwest. I noticed some things about the

survey, the projections on bed needs that Tom mentioned, but I would like to go into another point, and that's another reason why I think the Congress agreed to the new hospital construction in Minneapolis, the demographic study which predicted an increased demand for hospital beds among veterans in the coming decade.

According to official reports from the VA, the veteran population in Minnesota is increasing, not decreasing. The VA official report, dated September 1978, states that there are 556,000 veterans in Minnesota. And I'm talking about Minnesota because as we heard today, and as is obvious to all of you, Mr. Chairman, this is not a hospital for Minneapolis, or the Twin Cities, or Minnesota, it's a facility for the upper Midwest, and certain specified, specific areas of research and treatment, I think, for the whole Nation.

The VA official report states that there are 556,000 veterans in Minnesota. This is an increase of 4,000 veterans in the State in 3 years. Further, the number of older veterans in Minnesota, northern Iowa, and western Wisconsin is expected to more than double from 37,000 to 110,000 by the year 1990. These figures are not even taking into account that the Minneapolis medical center serves a seven State constituency throughout the Midwest. The testimony which was heard on previous occasions concerning the Minneapolis hospital often made mention of the empty beds.

Let me quote directly from this report at this point at which it addresses the ratio of supply and demand for beds, just to stress that one point here.

They talked about the St. Cloud facility. But as we look at 1990, and the year 2000, and that really isn't so far away, they come up with an increase of about 320 beds.

Mr. Chairman, the evidence is overwhelming that the new Minneapolis VA Hospital is needed now to serve the health needs of veterans in the upper Midwest.

Furthermore, the evidence shows that the need for this new facility will increase in the coming years. I think that's the key point. We, as a people, and as a government, are obligated to meet the health needs of our sons and daughters who serve in the defense of our country. We have asked them to sacrifice much to preserve peace and freedom for us all in our land. The time has definitely come where we will have to make a sacrifice, and we still have to acknowledge it is that, for our veterans.

This is not a new concept, Mr. Chairman, because all of us, I think, are aware, since the time of Abraham Lincoln, and before—Lincoln told us after that terrible struggle we went through as a nation, that we should remember and care for him who bore the battle, and for his widow, and for his orphan.

That obligation is still before us today.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Erdahl appears on p. 69.]

Mr. MORRIS. Thank you very much for your fine statement.

The Chair would like to congratulate the entire delegation, and the people of Minnesota should be very proud of all of you. I think you have certainly proven your point that the hospital is urgently needed in the area.

We have some questions here. The Chair would recognize the ranking minority member, the gentleman from Arkansas, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I don't have any questions, but I do want to thank this panel from Minnesota for being here and bringing us their views, especially Mr. Hagedorn and Mr. Frenzel, who have worked with me personally on this matter.

This committee authorized this hospital some time ago. Following that, Mr. Sabo, in the HUD and Independent Agencies Subcommittee also worked on it.

A few years ago, this committee reclaimed its authorization procedure for construction projects over \$2 million and thus this one fell within the purview of this committee.

We strongly supported it, and I very much appreciate you being here again. Even though this hospital is already authorized, it's a good forum for you to express your views and make them more fully known, and we appreciate it very much.

Mr. MOTTL. The gentleman from Pennsylvania, Mr. Edgar.

Mr. EDGAR. Thank you, Mr. Chairman.

Why do you think that your hospital was singled out by the administrator for deletion?

Mr. ERDAHL. I would respond "It beats me." I haven't seen any good reason.

Mr. VENTO. I think we're concerned about the arbitrary fashion, for the statement that came out that this was at the top of the list, if I guess you're going to defer activities and you don't want to move forward, that's where you might begin. I frankly am dismayed at this. We obviously would like to ask that question of the Administrator.

We're concerned obviously about the political maneuvering and so forth that might have occurred here. So we raised those questions. We don't see any logical reason for doing so.

Mr. FRENZEL. I think we are most upset by the fact that a project that ranked fifth in priority found its way into the administration's budget proposal this year and ours was skipped. We have no comment on Albuquerque. We don't know anything about Albuquerque. We assume that they have a good plan, too, but we also assume that they were behind us, that our priority had been firmly established and that we should be first, and we could find no good reason for the administration's rejection.

Mr. SABO. I might add that the relationship of the No. 5 project versus the No. 1 project, that finding funds for Minneapolis, that were appropriated in 1981, and finding funds for No. 5 in 1981. My guess is that it equates basically to the money question. It's a larger project in terms of cost than some of the others. I expect that probably is what motivated them, and we were told at some point that if the funds were authorized and appropriated in 1983 they could not be used in 1983. However it was, I think, clear from testimony that the project can begin if funds are appropriated in 1983. I expect that the outlay you would have would be very modest in 1983 because you would go through a series of construction stages. But you need the funds appropriated to begin the process. So I suspect it was dollar concerns.

Mr. EDGAR. The reason I asked that question is that one of my problems with some of the significant budget cuts that we've had over the last year have been the inequitable nature of those budget cuts. Questionable projects such as the Tombigbee Waterway and the central Arizona projects raise questions about equity in terms of water spending. I'm concerned, for example, in this fiscally conservative budget that we didn't cut a dime out of the Tennessee Tombigbee Waterway.

I'm mostly concerned that we didn't cut very much in terms of peanut subsidies or sugar subsidies. Then when I come to the Veterans' Affairs Committee I look across some of the construction projects that I've seen approved and built, and it seems to me that we're very fascinated with new structures in new areas where there has been migration, which are important. Particularly my colleague from Florida will talk at length about the number of veterans who enter the State of Florida per month, and the need for facilities there.

But I think that the point that all of you have made this morning about rehabilitation and replacement of aging facilities is one that our Federal Government has a great deal of difficulty with. Somehow as politicians and as public officials, we love to cut the ribbons on new systems. When it comes to replacing the existing systems, we either say let's make do with what we have because it's just not quite as attractive.

And I think that you do have a case in Minneapolis, in terms of quality of health care. We have a facility very similar in Philadelphia that was built in 1952, and a very good hospital director who is trying to make some major improvements in the quality of health care. But there are limitations when you have an aging facility or aging building.

I think there are some broader questions raised by the deletion of the Minneapolis hospital.

I hope that when Mr. Nimmo comes before us we can ask him some tough questions about the decision on the Minneapolis hospital. But I hope also we can look at some of the larger questions of how do we get to a point in the 1980's and 1990's where we replace, rebuild, and invest in the aging infrastructure of our Nation. Otherwise we will continue to see large deterioration in the quality of health care and, the quality of services that we provide.

Some of us have worked at looking at possibilities and imaginative new ways to fund some of these projects, in the form of capital budgeting.

I appreciate your testimony and I will take the opportunity to ask the Administrator some of the questions that you've raised this morning.

Mr. MOTTL. Thank you very much, Mr. Edgar.

The gentleman from Ohio, Mr. McEwen, do you have any questions for this distinguished panel here?

Mr. McEWEN. Not at this time, Mr. Chairman.

Mr. MOTTL. Thank you very much. The gentleman from Ohio, Mr. Applegate?

Mr. APPLEGATE. Thank you very much, Mr. Chairman.

I don't really have any questions, either. I'd just like to compliment the Minnesota delegation for articulating so well and present-

ing an excellent case for their hospital and I want to say that after hearing what they did have to say that I think it's a good idea that every delegation that comes in here has at least a couple of people that know how to play ball with the chairman. It's always an influencing factor.

But I do, I share some concerns and certainly am supportive of this because I can certainly see the need and in times when we're looking at the possibility of 10 to 12 million World War II veterans coming of hospital and medical age, medical care age, that we are going to need more and expressing concerns that Mr. Edgar had that we do wonder how all of these things are going to be funded.

But I think there are necessary things and I think the veterans should be cared for at all costs. That may sound a little expensive to say. But nevertheless, I think it's very, very important.

I want to thank you again for a very good case.

Mr. MORTL. Thank you very much, Mr. Applegate.

I think we all know how to play hardball when it's necessary, right? Especially, getting these facilities.

The gentleman from Alabama, Mr. Smith?

Mr. ALBERT LEE SMITH. No questions.

Mr. MORTL. Thank you very much, Mr. Smith.

The gentleman from Florida, Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman.

And I will refrain from saying that there are 5,000 veterans moving into Florida and they have been for the last 36 months straight. We have had 5,000 moving in. So, I won't say that again now.

But I do say this. That the case made by this delegation points out problems all over the Nation. Of course, where they're bad, in the rest of the Nation, Florida has really taken it on the nose. We have situations that are beyond comprehension. A lot of them are from Minnesota, I might add.

Mr. VENTO. There are probably going to be more coming into Florida. But, we also have an in-migration situation in Minnesota. And you know, we serve parts of North and South Dakota, Iowa, and Wisconsin.

The point is that if we look at short-term gains we might be able to defer construction and make some modest savings.

But, the long-term effect of putting off construction of the hospital is that we're just pushing ahead the costs, and we won't be able to meet the veteran's needs in an orderly fashion.

That's why we can't afford to have sort of a fits-and-starts program with regard to veteran hospital construction.

I'm very much concerned that the Administrator has made statements about the Twin Cities health care system in reviewing the Minneapolis project. Not that there are not problems within it, but I don't think we ought to try and solve those on the backs of veterans in our area.

We have had a veterans health care program that's moved forward and been cost effective with regard to veterans we serve.

We think it ought to be kept in place. As a committee, even if you may not have the same fervor that we have with regards to Minnesota facilities, I think you ought to be very concerned when

someone starts coming in and upsetting the track record that we have, and I think it's a good one.

If you start coming and moving the track sideways and putting other things in front of it, I think it does not speak well as an orderly process.

God knows we have enough trouble providing some degree of discipline with regards to construction projects. Once we attain that, I think that it goes with very little grace to have an Administrator come in after a few months on the job and make arbitrary statements about hospital construction. It does not bode well with the eventual needs, if you're going to have needs in Florida for instance. We want, of course, to go ahead in an orderly process. We're in line and we'd like to receive fair consideration in this area.

Mr. MICA. Let me say that I fully understand and agree and in any area of this Nation that has the immigration, we happen to be the leader in the country. This is where the adjustments need to be made. So, hopefully as the Administrator comes forth, we can help to channel that energy in a way that it will be directed in areas where there is in-migration need.

I think my colleague's comments from Pennsylvania were very appropriate, not only for the needs of expanding or renovating, but in both cases if that goal of changing construction schedules is channelled where the in-migration is, that net result could be a system to those areas that need it and not a stagnation in sending old formulas to areas that are no longer.

That's one of the things that I hope we can do here and we're going to talk about.

Thank you.

Mr. MOTTL. Thank you, Mr. Mica.

I think once you start running out of water in Florida, we'll see them come back to the Great Lakes Area.

The gentleman from Oregon, Mr. Dorgan.

Mr. DORGAN. Thank you, Mr. Chairman.

If he's getting Scandanavians migrating to Florida, he's improving a lot of the Floridians, I would say.

I certainly appreciate the testimony that has been given by the members of the Minnesota delegation and I just want to say I support your testimony.

I'm always interested in the ease with which we slip investment into the upper Midwest in defense installations. We have 300 intercontinental ballistic missiles housed on the prairies up there and that costs us a fair sum of money. But, it's more difficult to get the kind of money allocated and appropriated and finally spent on facilities such as this.

I just want to give strong support to your statement. I agree with your assessment of the need and I agree with your assessment of the urgency to move forward on this project.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you, Mr. Dorgan.

Again, the Chair would like to thank you for an outstanding job that all of you have done here this morning and we'll give you a helping hand.

Mr. DORGAN. Thank you, Mr. Chairman.

Mr. MOTT. Next, we will hear from the Honorable Robert Nimmo, the Administrator of the Veterans' Administration.

First of all, I would like to welcome you here this morning. It's certainly a pleasure to have you with us here this morning and we look forward to your statement and your entire statement, without objection, will be submitted into the record and you can either summarize or proceed as you deem fit.

Once we have proceeded with the questionings, after your initial statement, we'd just ask that your colleagues that would like to assist in the answering of any questions, if they would speak into the microphone for the record.

STATEMENT OF ROBERT NIMMO, ADMINISTRATOR, VETERANS' ADMINISTRATION

Mr. NIMMO. Thank you very much, Mr. Chairman. I'm pleased to appear before you and members of the committee to testify in support of the Veterans' Administration fiscal year 1983 construction authorizations and try to lay to rest some of the fears and concerns that have been expressed.

I will, as you suggest, Mr. Chairman, submit my statement for the record, and briefly try to explain what it is we really are about and what it is we're trying to do.

Mr. Chairman, and members of the committee, when I came on-board in the Veterans' Administration, I found that we had a 5-year construction plan totaling some \$5.7 billion. Most of the projects of which had their inception back in the 1970's, at a time when we still had a growing veterans' population.

I think it was not generally recognized at that time, the extent to which in the 1980's, we would be met with a declining veteran population but a rapidly aging veteran population.

In 1980, when Dr. Donald Custis became Chief Medical Director, he recognized some of the problems that were facing us and recognized that, perhaps when those projects had had their inception back in the 1970's, perhaps conditions were different and projections were not consistent with the facts that really confronted us.

So, Dr. Custis taking that into consideration initiated the medical district planning process which is a very sophisticated process. It's going to take some time to get it into place.

We won't have the input from the new planning process until time for the 1985 budget.

In the meantime, on the basis of what I learned by inspecting firsthand some of our facilities, nursing home care units, hospitals, and domiciliaries, it was apparent to me that some of those facilities were not properly designed and a good many of them, built in recent years, were extravagantly designed. Not in terms of providing service to the veterans but in terms of architectural niceties which were costing us as much as \$800,000 to \$1 million per facility.

At the same time, I became acutely aware of the situation that Mr. Mica referred to. For example, I was recently at an outpatient clinic in Orlando, Fla., and my question to the director was, what percentage of your patients are nonservice connected? He said, we

cannot treat any non-service-connected veteran. We simply do not have the resources.

I found that to be true through most of the State of Florida. At the same time, in most of the rest of the country, we are taking care of the well over 80 percent of people who come to our door.

We can handle with ease, the nonservice connected and in some areas, particularly in my State of California, I know one outpatient clinic that is actually out drumming up business to keep it viable.

So, these shifts in demographics, the shifting veteran population are very significant and they were not recognized back in the early, middle and even late 1970's when a great many of these projects had their inception and first got in the plan.

In addition to all of that, of course, we were mandated by the Congress to develop statistical objective criteria on which these construction projects could be based and on which they could be objectively defended. And I have to confess that we really did not have that kind of criteria.

So, this whole reexamination process came about from a variety of forces, one, as I mentioned was the recognition that some of the demographics and the projections made 7, 8, 9 years ago, no longer are valid.

Also we had some very serious design problems in some of our facilities. And I think it's fair to say, also, that we recognize that we are in a very serious economic environment in which we have to examine very carefully where and how we spend our money.

So, that's how all of this came about, and I would like to say, with respect to Minneapolis, that project has never been deleted from the construction plan. It is not deleted. We know we have to do something in Minneapolis and for that reason, we have continued the planning process. It's never been canceled.

It did seem that the most sensible way to attack this whole problem and given the urgency of getting budgets together, it was determined to let those projects that were in the plan for 1982 and 1983 go ahead and then reexamine and revalidate all of the projects for 1984 and the outyears.

I'm sure, Mr. Chairman, and members of the committee, you can imagine the criticism I would have gotten had I reexamined all 1984 and outyear projects except Minneapolis.

So, Minneapolis is one of those that is included in the revalidation process. We are going to either have a new hospital or a renovated hospital to handle the number of beds that have been programmed there.

My sense is that we're probably going to build the new hospital. I think the revalidation process will show that is the appropriate course. I think there may be some changes in design because as the preliminary design now stands, it is on a per-bed basis, the most expensive hospital that's ever been designed by the VA.

I think it's appropriate that we take a look at that and be sure that we have the proper design and proper space criteria in that hospital. But it's going to be built and there is no question about that. We're going to take care of the problem that's up there and I have never said otherwise.

So, Mr. Chairman, with those briefs remarks, I would again want to assure the committee that I'm not out to do evil. We are simply

trying to serve the veterans the best we can as efficiently as we can.

Thank you.

[The prepared statement of Administrator Nimmo appears on p. 71.]

Mr. MOTT. Very good job, Mr. Nimmo.

I'm sure that you're sincere that you got a most difficult task and you're trying to do the best you can. We're going to profer some questions to you. I think the Chair will invoke the 5-minute rule since we have good attendance here today and we'll go around as often as necessary but we'll try to be fair to every Member.

I have a few questions, if I may, to start it off, Mr. Nimmo.

House Report 96-114, which accompanied H.R. 4034, the HUD Independent Agency's appropriation for fiscal year 1982 contained the following language and I quote:

The committee urges the VA to advance the Cleveland Clinical Addition Construction Project on the current priority list from the fiscal year 1985 to the fiscal year 1983.

It is noted that this project has been authorized by the House Veterans' Affairs Committee and that it also is receiving priority attention from the advanced planning fund.

Therefore, the committee expects this project to be included in the 1983 estimates.

As stated in the report, this committee authorized the project for fiscal year 1982. A review of your budget request for 1983 fails to show any funds requested in 1983. Is that correct?

Mr. NIMMO. Mr. Chairman, if I may, I'd like to defer to Mr. Bill Sullivan who will respond to that.

Mr. MOTT. Sure. Mr. Sullivan.

Mr. SULLIVAN. Mr. Chairman. That is correct. Although the project has been accelerated, the preliminary plans were not completed in time for inclusion in the fiscal year 1983 budget. We are re-validating it, and we expect planning will be completed so that it can be placed in the fiscal year 1984 budget.

Mr. MOTT. What will be the added costs of this project by not including fiscal year 1983 requests?

Mr. SULLIVAN. We don't have an estimate as yet, Mr. Mottl—the VA's own figures add 11 percent due to inflation each year or a minimum of \$1.6 million per year, each year that it's delayed and if delayed 9 years, the costs could be doubled.

Mr. NIMMO. Mr. Chairman, in response to that question, I think that that inflationary factor was an estimate based on the rate of inflation that existed some months or some period back.

Whether that rate of inflation can be expected over the next several years is, of course, conjectural. All of us hope it will be substantially less than that.

Mr. MOTT. Can you just tell me then, why weren't these funds included in the budget, as indicated by the Appropriations Committee and authorized by this committee?

Mr. SULLIVAN. We could not use the construction money in fiscal year 1983. The money would have just sat idle. Therefore, we didn't think it prudent to request construction money at that time.

Mr. MOTT. It will be authorized next year then?

Mr. SULLIVAN. We anticipate that if it's revalidated that it would be in the fiscal year 1984 budget and at this time we don't see any problem with that.

Mr. MOTT. My last question at this time, Mr. Nimmo, you read the GAO report where it says that every year we delay construction that it has approximately an 11-percent inflation factor. It costs us a lot of money. Also, the change order—that really disturbs me.

So, we're proposing legislation. I'd like to have your cooperation in drafting the same. Follow the recommendations by the GAO so we can eliminate the 11-percent in delay of construction each year and also, that 8-percent change order really bothers me. I think this is where the taxpayer really is ripped off on these change orders. So, can you work with me in proposing and carrying out this?

Mr. NIMMO. Yes, sir, Mr. Chairman. I share your concern. I think one of the problems we have had with proliferation of change orders not only is a weakness in the planning process but also reflects what has heretofore been the long span of time between inception and execution. I think in this whole process that we're going to go through that we will be able to develop the kind of criteria that we need and the kind of improved planning so that we can shorten the span between inception and execution.

Mr. MOTT. It's a must if we're going to have prudent planning so we can eliminate this 11 percent. It's ridiculous that the taxpayers are shortchanged. Now, those change orders, that's the area, where I think the taxpayers are really ripped off.

Mr. NIMMO. I quite agree.

Mr. MOTT. We want to eliminate those two areas and I think we can save the taxpayers millions and millions of dollars each year.

I yield to my gentleman friend from Pennsylvania, Mr. Edgar.

Mr. EDGAR. Yes, Mr. Chairman. On your previous question, I want to get clear the answer that I heard. Was your answer that the money has been authorized for planning; for the Cleveland hospital?

For Cleveland, the money has been authorized?

Mr. SALMOND. No, sir. It has been authorized by this committee but not by the Senate.

Mr. EDGAR. And for Minneapolis, has the money been authorized?

Mr. SALMOND. For Minneapolis, the design money was authorized by this committee and in the Senate committee, it was authorized for design and site preparation.

Mr. EDGAR. And for the Minneapolis facility, that's what's being held up?

Mr. SALMOND. It's not being held up.

Mr. EDGAR. They're going ahead with those funds?

Mr. SALMOND. On the completion of the revalidation process, I would expect that we would ask for a reprogramming of the money that we already have so that we can get on with the site preparation for the Minneapolis hospital.

Mr. EDGAR. And the money appropriated for 1983, is that being held up?

Mr. SALMOND. No money is requested in 1983 for Minneapolis.

Mr. EDGAR. OK. So, nothing's going to be done on the Minneapolis hospital between now and at least January of 1983?

Mr. SALMOND. That's not correct, sir. What I said was that on the completion of the revalidation process for Minneapolis we could then proceed, based on getting a reprogramming of the money that we already have for design. We have \$15 million. We have a need to use about \$4 million of that to do site preparation work, but in no way could we get under construction on the major building in 1983.

Mr. EDGAR. Thank you, Mr. Chairman.

Mr. MOTTL. The Chair will recognize the gentleman from Ohio, Mr. McEwen.

Mr. McEWEN. Thank you, Mr. Chairman, if I could just continue on there.

I don't understand the reprogramming part. What does that mean?

Mr. SALMOND. We have \$15 million that's been appropriated for the design of Minneapolis. Our architect/engineer contract costs did not approach that amount. So, we can use money that's already available to us, rather than having the Appropriations Committee appropriate \$267 million which would just sit in the bank. We'll use the money that we already have through a reprogramming approved by your committee and also by the appropriations subcommittee so that we can go ahead with the program.

Mr. McEWEN. I thought I understood you to say that it was already authorized for site preparation?

Mr. SALMOND. In the Senate only.

Mr. McEWEN. So, your reprogramming is that you want permission from this committee to use it?

Mr. SALMOND. We would, upon the completion of the revalidation process, come to you and ask for that.

Mr. McEWEN. Thank you.

Mr. NIMMO, this revalidating process, what sort of timeframe do you think we're looking at for the Minneapolis project in particular?

Mr. NIMMO. Mr. McEwen, I have asked the Facilities Planning and Construction Committee to give most urgent attention to the Minneapolis project and we expect to have that revalidation completed by fall of this year.

Mr. McEWEN. In terms of Veterans' Administration action, is that expeditious?

Mr. NIMMO. Well, in August or September we will be in the next budget cycle planning phase, putting together our fiscal year 1984 budget proposals, and we want to be prepared to include Minneapolis in that budget, assuming the requirement is there, and I expect that it will be.

Mr. McEWEN. Do you have a priority list for revalidation?

Mr. NIMMO. Yes, we do, and Mr. Sullivan can speak to that in detail.

Mr. SULLIVAN. We have worked out with the Department of Medicine and Surgery and the Office of Construction the group projects which are to be revalidated for fiscal year 1984. While we are expediting the revalidation of Minneapolis, all the fiscal year 1984 revalidations must be performed essentially simultaneously in

order to complete the agency's budget preparations in time for our budget submission to OMB this fall.

Mr. McEWEN. I didn't hear the first.

Mr. SULLIVAN. Yes; we do have a prioritized list.

Mr. McEWEN. Wonderful. Thank you.

Mr. Nimmo, do you know who advised you on the oversupply of beds in Minneapolis that precipitated this prior storm?

Mr. NIMMO. Mr. McEwen, I guess I didn't have any real advice and I probably should have had. One of the non-service-connected illnesses I occasionally suffer from is foot-in-mouth disease. And I guess I was suffering from it when I made that analogy and I certainly wish I had never done it.

Mr. McEWEN. Surely.

Mr. NIMMO. The context in which I made that observation was in talking about the decreasing veterans population and the increase in the aging veteran population. And the proliferation of hospitals under the Hill-Burton Act back in the 1960's many of which are now in serious trouble. And we have, for example, one that I'm aware of in California that the county supervisors are trying to get rid of. In that kind of situation, perhaps it would make more sense for us to buy the hospital or lease it for 20 years, while that surge of aging veterans goes through the system, rather than spend \$250 million, \$200 million, or \$400 million for a new facility.

That was the context in which I used the Minneapolis example, and I wish to goodness I had never done that.

Mr. McEWEN. Let me just say, Mr. Administrator, that when Congressmen find an administrative official that may have made a slight error at one time or another, we can be meaner than junkyard dogs in pointing it out and, besides, it's not very often that we get to yell at anybody.

It seems that when it gets toward the end of even-numbered years, we become increasingly testy. I appreciate the fact that you're dedicated to helping veterans. I think you understand that we, on this committee, are as well. And I think we've pretty well got this issue settled to the benefit of all of us.

I have some other questions in mind, but I'll save those for later on. Thank you, Mr. Chairman.

Mr. MOTT. Thank you very much, Mr. McEwen.

The gentleman from Pennsylvania, Mr. Edgar.

Mr. EDGAR. Thank you, Mr. Chairman.

I, too, have quite a number of questions for the Administrator, but I appreciate your coming this morning and giving us an opportunity to talk about the whole issue of medical construction, medical needs.

First, in your opening remarks, you mentioned the need, particularly in areas where there's high in-migration of population and where there is demographic shifts, to being aware of construction needs for veterans' hospitals.

The arguments that Congressman Mica makes for Florida are clearly important to look at. The demographics do change over time, and people do move to different places. One concern that I had, representing an older city in the Northeast and Midwest region of the country, was that some of those veterans moving to Congressman Mica's State are pretty well off. They're able to, in

some instances, have some health care benefits that pay their own way.

There are, however, in some of our older communities of the Northeast and Midwest, those veterans who are immobilized by high interest rates, immobilized by small pensions, immobilized by a number of economic factors that don't give them the opportunity to move to the great State of Florida or to Texas or to California.

That brings us to those older facilities; Minneapolis was cited, Philadelphia could be cited as a facility that's 30 years old. My concern is that the Veterans' Administration recognize that not only do we have rehabilitation and replacement needs, but we have an aging veteran population that will, in many instances, need and put more pressure on those existing facilities throughout the country.

I wonder if you have any comment on what you see as the next 10 years of need for the veterans' health care and medical facilities in terms of providing quality care?

Mr. NIMMO. I think what we will see is an increased need for nursing-care facilities. The requirement for acute care may or may not decline.

I think the kind of pressures that you're referring to in some of the metropolitan areas that, where there may be a declining veteran population overall, but nevertheless an increase in the demand for medical care for the aging population, will be reflected in the input data from the [MEDDIPP] planning process, the medical district initiative planning process, which I referred to earlier.

That is a process by which the local medical director, chief of staff, and others can assess the needs of the people in the local district and put that information into the planning process here in the central office.

I recognize, as I think all of us do, the problem you alluded to, and we certainly hope that we are taking those factors into consideration in our planning process.

Mr. EDGAR. Would you agree that acute care is the heart of the quality of the veterans' medical system?

Mr. NIMMO. There is no question about that, Mr. Edgar. One of the concerns we have for the maintenance of quality acute care is the fact that most of our patients in years to come are going to be very elderly and, perhaps, their illnesses and conditions that have to be treated will be in a relatively narrow range. It may be difficult to maintain the medical specialties that we'd like to have in those acute-care facilities.

Mr. EDGAR. As I add up the numbers, statistically, in terms of replacement of existing hospitals that are 30 years of age or older and obsolete in many of their health care areas, and as I add up the numbers for nursing home facilities, domiciliary facilities, as I add up the numbers in terms of the in-migration areas for new hospitals, if we have present rate of funding over the next 10 or 15 years, the present rate of funding is not going to meet the present rate of need. Would you agree with that?

Mr. NIMMO. I think that may be a very real possibility. On the other hand, because it may be that the requirements for acute care go down while requirements for nursing care go up, I've asked Chief Medical Director Dr. Custis to examine very carefully all of

our facilities, all of the acute-care facilities, and see whether and to what extent it may be appropriate to convert some of those facilities in whole or in part to nursing care rather than acute care. We have a number of hospitals, 12 or more, which have an occupancy rate of under 70 percent. It may well be that we can convert wards, wings, or perhaps entire facilities, to nursing care rather than acute care. It's a matter that has to be very carefully looked at, but I think that there may be solutions other than new construction which, as you know, is so very expensive.

Mr. EDGAR. I have some followup questions, but I see my time has expired and I'll save those for later.

Mr. MORTL. Thank you very much, Mr. Edgar. The gentlelady from Massachusetts, Mrs. Heckler?

Mrs. HECKLER. Mr. Administrator, I appreciate your candor this morning. I think we are all inclined to make judgments based on what we know best, and, coming from California where you have that experience, I can see where your judgment would be very influenced by it.

I think that it also was quite remarkable to have so many members of the Minnesota delegation here today. That is not a common experience before this committee.

So, obviously there is an acute problem, I would say, in Minnesota. And I wondered between the two options, that is, the option for refurbishing or investing a great deal of money in the existing hospital, and the option for new construction; can you, at this time, give me what you consider to be the priority between the two? What would be more financially feasible and appropriate for the VA?

Mr. NIMMO. As between new construction and renovation in Minneapolis?

Mrs. HECKLER. Yes.

Mr. NIMMO. No, I'm sorry. I really cannot speak to that. You know, the revalidation, reexamination process has not been done there.

A decision, of course, at some point was made that new construction made more sense than renovation. And I assume that somebody, on the basis of all the facts available to him, made that decision in good faith. So, I have no reason to believe that it was a bad decision.

I just think that it's appropriate, since we are reexamining all of the other 1984 and end-out year projects, that we must necessarily include Minneapolis.

Mrs. HECKLER. When will the decision be made in terms of Minneapolis?

Mr. NIMMO. We are going to have the decision made, as I said earlier, by August or September, perhaps even earlier. But we want to have it done, certainly, before the preparation for the 1984 budget.

Mrs. HECKLER. I see. Well, I'm sure that you'll run into the problem that every Administrator has. There is the unspeakable problem that everybody on this committee knows all about. That's the problem at OMB. So, I think that we and the committee have to be prepared to be supportive of the construction where it is so badly needed.

Mr. NIMMO. Mrs. Heckler, I don't have that much concern about OMB. If I can go to them and defend what I propose, and if I can say that Minneapolis is absolutely essential, that we've reexamined it, we know that the veteran patient needs are there and that we can defend our proposal, whatever it is on logical, clearly objective grounds, then I have no concerns about winning that battle with OMB.

Mrs. HECKLER. I'm glad that you have that good a relationship because, in the past, we've had very difficult times; although, I think that Mr. Stockman can be persuaded on a number of issues, it always takes a very strong case and a great deal of pressure.

So, I think that many of us will be supportive of the Minnesota application, particularly because of the strong case that was put in today. And obviously you, yourself, see great merit in it at this point, it would seem.

I'd like to get into the issue of the aging veteran, because it is a constant concern. Really, for the poorer veteran, it isn't possible for him to move to the Sun Belt States and we, in Massachusetts, want to keep them in the Frost Belt, and many of us expect that they will live their lives there.

In that regard, I'm just very concerned about the geriatrics program which I've mentioned before. I see that as a means of keeping veterans out of hospitals as an alternative to institutionalization. And I see it as a means of avoiding even the nursing care or postponing it.

Now, this is not only good for the veteran but also saves money for the Federal Government, because the longer we can keep people out of institutions, the more fortunate we're going to be in terms of their lives and in terms of the cost to the Government.

I see the geriatrics program as offering that kind of hope. I'm just wondering what the future of that program is, however, and how you view it.

Mr. NIMMO. I, of course, am not a medical professional. My perception is that the advancements of medical science are coming at an unprecedented rate in all areas as well as the care of the aged.

I think that, yes, the geriatrics program is a needed, necessary, essential program that has to be expanded as funds are available to us. But that program must have the same close examination as all of the other medical advances that are coming so rapidly in our society.

I think all of the people of the country, as well as the aging, are going to benefit from these advances. That's why, despite some reports to the contrary, I fully support affiliation and fully support research, even though I think they are also things that need to be examined.

Mrs. HECKLER. I'm very encouraged to hear your statement and have a clarification of your position because I think it has been perhaps misrepresented in other reports.

Mr. EDGAR. Thank you. Congressman Mica?

Mr. MICA. Thank you.

I almost considered asking for unanimous consent for an extra minute to talk about whether or not people in Florida are poor or rich. My colleagues have raised this issue.

Mr. EDGAR. If the gentleman will yield? We said "some."

Mr. MICA. "Some." I might just say, seriously though, many, many of our veterans who are coming to Florida are not very wealthy at all. In fact, that is the reason they come. Fuel bills alone—I shouldn't say this to the committee, because it may incur some more comments—but the savings on fuel bills alone are a major reason why many retirees sell their homes and come to Florida. With their equity, they can come to Florida and live a reasonable life in the Coconut Belt.

But really they do save money. They are for the most part—those who are inundating our veteran system—are on very, very meager incomes—veterans' pensions and veterans' benefits.

In fact, that figure I keep quoting, 5,000 veterans a month, the actual figure is 7,000 a month, who notify the VA that they are moving their benefits to Florida.

If there was a veteran who wasn't receiving benefits, we really wouldn't know, so the fact is that in many cases, these are people in extreme need.

The Administrator was just down there when we opened a VA clinic last month in Broward County, Fla., and I swear it looked like we were opening the most massive VA facility in the Nation. We had every kind of group and hundreds, close to thousands, of people lined up for this small clinic and as soon as we opened the doors they were lined up for service.

So the fact is, and the records show very strongly the need for facilities in Florida and those veterans that are moving, for the most part, are the ones who really have a severe need.

Now, I would like to just touch on Minneapolis-St. Paul. I usually talk a great deal about Florida. I am the only member from Florida. We are the sixth largest State and we have these severe problems that we're trying to focus fairly on in Florida.

As I understand you today, you have made a commitment that you will move forward with the Minneapolis facility?

Mr. NIMMO. That is correct.

Mr. MICA. Second, that you have retracted your comments and wish you had never said them—about overbedding. And third, that you have revalidation procedures and that you intend to maintain the level of service around the country that presently exists. I would like to see them maintained or exceeded, frankly.

With those kinds of commitments, I hope we can go forward in a cooperative manner. I would support looking at all of these revalidations but I don't see any other veterans' population having their service cut in any way just because they are trying to shift around.

I do think you mentioned and I quote you, that in some of your facilities they are actually out "drumming up business." Just this morning, on the wire, just as I came from my office and got here, I understand they put out a bulletin from the VA hospital in Miami. May I read just a portion of it? It says, "The veterans' population in the State of Florida continues to grow at a staggering rate."

This was sent out by the Administrator there and it is, therefore, necessary that we curtail outpatient services to nonservice connected veterans who are not entitled to priority treatment on a con-

tinuing basis and to service connected veterans rated less than 50 percent.

I dare say that if this announcement went out to any veterans' population anywhere in the country, there would be a massive outcry and we are going to continue to have it in Florida. It will probably be less there because they are used to a little less service.

They are implementing a whole policy change of starting to plan our discharge at the same time you are admitted to the hospital and then arranging for you to go to a private doctor and pay out of your own pocket. That is the only place in the entire country.

So, what I am asking, and what I hope you can do; is it possible for you to declare any kind of a veterans' emergency or a need emergency or a medical care crisis? Is it possible to do that?

Mr. NIMMO. I don't know. I'd have to defer to general counsel on that kind of question, Mr. Mica. I think it is unlikely that I would be able to declare a medical emergency or whatever you might describe. But I would say, on the other hand that—

Mr. MICA. If we did this nationwide, I don't think there would be riots in the streets or a storm in Washington. Because we are doing it in the small geographical area of Florida, south Florida, it probably will be confined to my district office and a few other Members in south Florida.

As you indicate, it is a crisis—95 percent of nonservice connected veterans aren't being seen anyhow. Now they are cutting off service connected, less than 50 percent, veterans. That's unfair.

I see that my time is up.

Mr. EDGAR. I yield to the gentleman 2 additional minutes.

Mr. NIMMO. That's why, of course, our whole planning sequence has to be much more responsive, much more rapid than it has been heretofore so that we can move our resources, target our resources to the areas of greatest need.

That's been one of the problems that I alluded to earlier, that it's an 8- or 9-year sequence from inception to execution sometimes.

We have to get that time frame down and place the resources where the needs are. I think the answer to a good part of this problem may be a greater emphasis on outpatient clinics than we have had heretofore.

Mr. MICA. That's the point though. Can you shift immediately any of these personnel and any of these resources in the area? I am not talking about going into Minneapolis or any other area and cutting service—we are turning away veterans—where there are doctor-patient ratios and where the ratios are beyond what they require shift some of them by administrative decision?

Mr. NIMMO. It is very difficult to do but maybe Dr. Jacoby could speak to the problem more thoroughly than I can.

Dr. JACOBY. Mr. Mica, I recently had a letter from and a long conversation with, the chief of staff at the VA Hospital in Miami, Dr. Rosenberg. We have a group at the present time looking at the particular problems as they relate to the Miami situation and we have every intention of alleviating those problems in every way possible.

Might I comment, too, that in keeping with the wishes of Congress we have a study which we recently updated the members of the committee on—in which we are evaluating the situation in the

State of Florida and we will have a report in the fall for you on our assessment of what the requirements will be in Florida.

As a final comment I would only say in defense of many of those who were in the Veterans' Administration beforehand, the needs of Florida have been very well recognized.

I would point to the past 10 years—to the hospitals in Miami, Tampa, Gainesville, the current construction in Bay Pines, the opening of the clinic in Riviera Beach, Fort Myer, Broward County, and currently following the requirements of Florida, we will be opening a new clinic in Pensacola. I hope that would provide evidence to you that we recognize the problems in Florida and that we are trying to alleviate them in every area where we possibly can.

Mr. EDGAR. Would the gentleman yield?

Mr. MICA. I would be happy to yield.

Mr. EDGAR. I wonder if Mr. Murphy or someone on the panel might be able to tell us about the legality of the accusations that have been made that service connected veterans may, in fact, be denied medical care?

Mr. MURPHY. I would say, Mr. Edgar, that it would depend on the individual medical condition of the veteran. As you know, there is a priority system set forth in law, thus an evaluation process would be undertaken when the veteran requested care.

Mr. EDGAR. Doesn't the law say that the service connected veterans will receive medical care through the VA or its equivalent?

Mr. MURPHY. It says, within the limits of Veterans' Administration facilities service connected veterans will receive—

Mr. MICA. Is there any place in the country that has cut off care—other than this memo—to 50 percent or less service connected?

Mr. MURPHY. Mr. Mica, I haven't seen the memo and I am not personally aware of any place in the country that has cut off care as you have described. I would have to point out that from some of the references that Mr. Mica made concerning what is contained in the press release, the memorandum, that it may be referring to the authority to contract care for service-connected veterans rated less than 50 percent for non-service connected conditions.

Mr. EDGAR. If the gentleman will yield? Within the next week, if you could provide for the record an analysis of this particular situation and provide a copy to Mr. Mica, it would be very helpful in terms of the legalities of the actions taken by the hospital system in Florida.

Mr. MURPHY. I will be pleased to do that.¹

Mr. EDGAR. I yield to Mr. Smith at this time. Five minutes.

Mr. ALBERT LEE SMITH. Thank you, Mr. Chairman.

Mr. Nimmo, as a young member on House Budget Committee, wrestling with the problem of what appears to be maybe, \$120 to \$165 billion deficit for fiscal year 1983, I commend you for reviewing the plans to construct the Minnesota facility, because it is priced so high so that you assure getting the best use of the dollars available while trying to eliminate any waste in construction costs. And, as you have indicated, you are trying to target resources to do the greatest job possible.

¹ See p. 73.

And also, I note that you are seeing if it's possible to take existing facilities and to renovate them and bring them up to the standards to meet the needs that we have today. We are straining on the Budget Committee to try and find ways to reduce the deficit and to live within our means and so I commend you and the Veterans' Administration for helping us do that. And I think this is something that we need to see done all across the spectrum of various Government agencies. It's a painful time with over a trillion dollar debt but something we've got to face up to.

I understand that you have about \$192 million in the 1983 budget for so-called minor construction projects. And in your reviewing of major projects which is \$2 million and above, do you also intend to review those projects that fall in the category below the \$2 million?

Mr. NIMMO. No, sir. We do not have plans for the minor construction projects. I wish that we had the resources, the capabilities to do that, but the task of re-examining on a timely basis those major projects is just all we can handle.

Mr. ALBERT LEE SMITH. Do research projects materially add to the construction costs?

Mr. NIMMO. Medical research projects? No, not in and of themselves. The construction costs are increased through affiliation because of the need for educational buildings and for greater space because of teaching requirements. But I would not say that research adds to the cost.

Mr. SMITH. I encourage you to continue to find ways to be more efficient in the use of the money that is made available so we can get out of this dilemma that we find ourselves in and I hope other people in charge of various Government agencies are striving too, to do the same.

Mr. NIMMO. Thank you very much, Mr. Smith. I certainly appreciate that. As you know, we are dealing here with a very sensitive constituency and one which obviously we have to serve and serve in accordance with the standards that are set by the Congress.

So, all we're really trying to do is within that commitment find ways of containing costs, doing what it is we are required to do in the most efficient manner.

Mr. ALBERT LEE SMITH. I agree we have a definite obligation and responsibility to help and the question is, does the trust and the responsibility that we have with the dollars that are made available to us being used to the maximum? I hope that we all are striving to do that.

Mr. NIMMO. I would just quickly say that I am pleased by the number of veterans since the announcement of this revalidation project who have written to express their approval of what we're doing and the need for looking carefully at the expenditure of dollars.

Mr. ALBERT LEE SMITH. Thank you. Mr. Chairman, I'm giving up the balance of my time.

Mr. EDGAR. Thank you. Mr. Dunn.

Mr. DUNN. Thank you, Mr. Chairman. I'd like to continue a little bit along the line of my colleague, Mr. Smith. In the area of cost overruns, it seems a worthwhile effort to target some of our inter-

est to that, if indeed we can get cost overruns down, we can have more money left for other hospitals.

In talking with Secretary Weinberger in the Defense Department, 2 weeks ago, he enumerated to me some of the changes that the Defense Department was making in very simplistic terms in the multiyear contracting which is going to save a great deal of money. But also, in more detail.

My question is in the nature of what action has your administration taken with respect to past cost overruns in hospital constructions. Are there any specifics that you could provide my office with? What are you doing differently than has been the case in the past?

Mr. NIMMO. Well, I guess up to this point, Mr. Dunn, we really haven't done very much differently. We're just in the process of examining ways and developing ways that we can prevent cost overruns.

One of the ways, again, is to shorten up that timespan between inception and execution. The other is to be more careful of what we plan. For example, consider nursing home units. We are developing a more-or-less standardized plan so that each project is not something all by itself. We want to get away from what I referred to earlier as the architectural niceties as well as some of the architectural mistakes we make when we design one project at a time. By developing some basically standard plans, we will avoid a lot of those cost overrun problems.

Mr. DUNN. My experience in construction leads me to this. There are two areas you get in cost overruns. One is in the planning stage, where you establish a budget of x dollars and an architect submits a plan that the contract is bid on that is considerably above that. And the second area is once the building is under construction under the contract agreed to, then the cost overruns come because of change orders. I think there's very definite ways to reduce those. And again, Secretary Weinberger described previous contracts as very advantageous to the industry and not so advantageous to the Government.

One of the very simple things you could do is establish a budget of again, x dollars and in giving the blueprints to the architect, say that if the building, once it is bid out by general contractors does not come in at that—because indeed, you're relying on the architect's pencil which can get very expensive at times—you simply won't pay their architectural fee. It's a very simple tool. Architects don't like it, but nevertheless I've used it myself to work very dramatically. You end up with architects drawing buildings that are budgeted.

And the other thing is once the building is underway, not to build in incentives for the contractor to submit cost overruns. There's some very specific ways that you can do it—Weinberger's office is doing it and—if you get a chance I'd like to see some of the details of what you're doing in the actual contract writing stage.

Mr. NIMMO. We'll certainly do that.

Mr. DUNN. One other question on the VA hospital in Allen Park. Has any decision been made there yet as to whether we're going to modernize? I know some of the veterans groups have suggested to

me that we build an entirely new hospital associated with Wayne. Can you tell me where you're at in that process?

Mr. NIMMO. I will defer to Mr. Sullivan, please?

Mr. SULLIVAN. We're going to be making an award for a technical assessment as well as development of various construction concepts for that facility in the near future. Upon completion of that work, we should be able to report to your office exactly what we've decided.

Mr. DUNN. I would appreciate that. And I thank you.

Mr. VENTO. Thank you.

Mr. Vento testified earlier and as a Member of Congress, I'd like to give him 5 minutes to ask you a few questions.

Mr. VENTO. Mr. Nimmo, I thought it was important that you sat and listened to us, so I wanted to sit and hear you out with respect to what your plans are. As you can see from the presentation by the members of the Minneapolis delegation, this is an extremely important issue.

Some 5 weeks ago we sent a long communication to you which apparently you have not responded to at this particular date. Is there any special reason why you have not done it?

Mr. NIMMO. No, there is not, and I apologize for that, Congressman. We'll get it out and get a response to you immediately.¹

Mr. VENTO. I think all of the Members of Congress from our region signed that letter and have very lively interests in this particular hospital, Mr. Nimmo, as is evidenced by the participation here today.

The problem that I have, is with the revalidation. Everyone is for efficiency and eliminating misuse of money, of course. But we have been sort of chasing our tail around the tree here and I don't think we want to see the wheel reinvented with respect to this issue.

Mr. Nimmo, in dealing with life safety issues, are you aware that there are certain fire code problems with regard to the Minneapolis facility?

Mr. NIMMO. Yes, sir, I am aware of that.

Mr. VENTO. And they don't put Minneapolis into the same category, apparently as the other facilities that you suggest need replacement because of life safety or aging veterans needs? We have aging veterans in our areas, too, do we not?

Mr. NIMMO. Yes; that's true.

We are aware of the fire safety code problems there but it is a major renovation or replacement project obviously.

Mr. VENTO. If I understand correctly, if indeed this hospital had fallen into the 1983 budget, it would not have to go through the reevaluation; is that right? Is it sort of a "Catch 22" type situation for us?

We think that it should have fallen into the fiscal year 1983 budget and you're saying well, now, that's it's slipped ahead to the 1984 budget or you've slipped it ahead to the 1984 budget, and therefore, it has to undergo the same treatment as all the other projects over a certain amount and so forth and so on.

You know, the thing is, you're putting it into the fiscal year 1984 budget and then saying you don't want to treat it differently. Our

¹ See p. 74.

concern is that it doesn't belong in that particular budget at all. It belongs in the 1983 budget category and I think that that is causing me and I think will cause my colleagues, some concern.

Mr. NIMMO. Well, as we've said, Mr. Vento, we were not far enough along in the planning stage to get it in the 1983 budget. We are still in the planning stage.

Mr. VENTO. I appreciate that one of the things you also told members of the committee, is that this hospital is going to be one of the most expensive per-foot hospitals that has been constructed. So, obviously, you've got enough information that you know what the costs are here as opposed to some other areas.

I'm well aware of the architect's problem in terms of selection. In fact, you'll find some letter on record of my taking to task the Veterans' Administration for not awarding that particular contract in a lively fashion. Not just because it wasn't awarded to a local company, but nothing happened after the contract was awarded.

So, we've been involved in the contract process and have been somewhat frustrated by it. I might also add to your point about the highest cost, that, the fact is, this is the most recent one that you've looked at.

So, I don't know if your claim really is a fair assessment, especially if you're comparing it to other health care facilities in our area.

Isn't it true that the Minneapolis VA Hospital is one of the most recent, if not the most recent project you've looked at? Is that not true with respect to looking at it on a per foot basis?

Mr. NIMMO. Yes, Minneapolis is one of the most recent replacement hospital projects and one of the most expensive we designed to date on a per-bed basis.

Mr. VENTO. So, the Minneapolis project will or may be eclipsed by other facilities in Cleveland or some place else, given the same timeframe in construction; is that not right?

Mr. NIMMO. That's conceivable.

Mr. EDGAR. Will the gentleman yield?

Mr. VENTO. I'd be happy to.

Mr. EDGAR. While the gentleman has been asking questions, I've had a chance to review a couple of the reports and discover that in the 1981 5-year plan, Minneapolis, Minn. is at the top of the list: 1980, 1981. In the next 5-year plan it's also at the top of the list in 1982.

Then, in the 1983 budget, it's not even on the list. Is there any reason for that? Shouldn't it have been on the list at the top with maybe an asterisk saying we're going to get to it? I have the current year authorizations on page 25-1 of the budget you offered.

Mr. SALMOND. Mr. Edgar, you talked about the 5-year plan?

Mr. EDGAR. This is the 1982 to 1986 5-year plan where it's on the top of the list and here is the 1981 to 1985, that's on the top of the list.

Mr. SALMOND. Yes.

Mr. EDGAR. It just seems strange that it suddenly disappears from the 1983—

Mr. SALMOND. It doesn't disappear, sir. This is not a 5-year plan that you're holding up there. The 1983 to 1987 plan, Mr. Edgar, has not been submitted.

Mr. EDGAR. So, you think that it's going to be on the top of the list again or near the top?

Mr. SALMOND. Yes; our expectation is that it will be.

Mr. EDGAR. It seems a little strange that it's not on this list at all for current year authorizations. It's not on the document with the footnote.

Mr. SALMOND. I'm not sure what list it is you're looking at, Mr. Edgar.

Mr. EDGAR. I'm looking at the document that was in front of us today on the table prepared by your staff.

Mr. CASTEEL. Medical construction and leasing authorization requests; 1983 budget submission.

Mr. SALMOND. This is not the 5-year plan.

Mr. EDGAR. No; the point I'm making is that's in the two 5-year plans and then it suddenly disappears in the 1983.

Mr. NIMMO. It doesn't disappear, sir.

Mr. MURPHY. Minneapolis has been authorized by this committee.

Mr. EDGAR. I'm still confused as to why you didn't asterisk that or make some reference to it here in this document.

Mr. SALMOND. If you'll go to the back of the book you'll find where we have to make a report, a status on all those projects that have been authorized. You'll find that Minneapolis is listed as a replacement hospital and the status is that we're in working drawings from some early phases as well as in preliminaries for later phases.

Mr. EDGAR. OK. I yield back to the gentleman.

Mr. VENTO. Thank you. I appreciate the chairman pointing that out and I hope that the issue becomes clarified. The one point I wanted to talk about is the authorization process. It's my understanding that the provisions in the bill already provide for site authorization work, so I don't think that throwing that particular bone to this delegation, saying now you've got somewhat of a victory is going to be satisfactory to me and I don't believe to others.

We already have authority in the law for that. You can use that money for site authorization. I'm advised of that by the counsel here and I don't understand why you need additional language to use that \$15 million. That has been appropriated for planning, and I think it can be used for site preparation.

Traditionally it has been used, I'm advised for that particular purpose. Is there any disagreement or concern?

Mr. MURPHY. I think the concern arises from the actual language of the appropriations statute. Although it is clear that the authorizing transmittal from this committee refers to design and site improvements the Appropriations Committee language dropped the words "and site preparations."

Mr. VENTO. I get very concerned about a full revalidation process. I noted that you tempered your remarks about 2,000 empty beds in the Twin Cities, but yet, you repeat that particular phrase in your prepared testimony, Mr. Nimmo. I do not think those empty beds exist.

I'm very concerned and I think the committee should be concerned about this hospital. I would hope that we could get this back into the 1983 budget and allay the fears that exist. This proj-

ect has been thoroughly examined. It's been examined up and down, back and forth, and I think the justification for it is very great.

I will not take further time with the committee, but just let me point out and reemphasize again my strong support for the hospital and opposition to its absence in the authorization requested by the Veterans' Administration.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. And thank you for your presence today.

Mr. Administrator, Mr. Hammerschmidt has a series of questions he'd like to submit for the record and I'll make sure that you have those available to you.¹

Also, you mentioned a priority listing for the revalidation of not only the Minneapolis hospital but a listing out of the priorities for your revalidation. Do you have that list of priorities with you? Are you developing that list of priorities and if so, will you supply that for the record?

Mr. NIMMO. We will supply that for the record.²

Mr. EDGAR. Thank you.

I'd like to draw your attention to February 26, 1981, General Accounting Office report entitled "Federal Capitol Budgeting, a Collection of Haphazard Practices," where it moved through a whole process of finding a logical and clear way to construct public infrastructure.

On page 29 of that document, printed a year ago by the General Accounting Office, it says the following and I'd like to just read a couple of paragraphs which relate to Mr. Vento's comment about the age of equipment.

Veterans' Administration's facilities are becoming functionally obsolete. Many of its hospitals are structurally sound but do not have enough room or the correct space configuration to accommodate modern medical equipment, outpatient facilities or air-conditioning and duct work.

Currently, about one-third of the VA's 172 hospitals have no air-conditioning in the patient quarters. Although the agency is taking a hard look at its medical facilities, it is not replacing or renovating them fast enough to upgrade them to the new higher standards of hospital occupancy.

Facility age, change in the life safety and electrical codes, requirements of the Joint Commission on Hospital Accreditation, changes in medical technology and insufficient construction funds are the reason the VA gives for its obsolete medical facilities over the last 10 years.

The 1978 GAO report states:

One, that many of the facilities under the VA Department of Medical and Surgery are technically obsolete.

Two, half of the hospitals currently in use were constructed before 1950. The oldest in 1888. A few of them were actually intended to be temporary facilities. During 1975 to 1979, VA's outlays in 1972 constant dollars for capital investment averaged about \$142 million a year. This is a considerable increase over outlays made in the three prior five-year periods from 1960 to 1974 which range from an annual average of \$91 million a year. This is a considerable increase over outlays

¹ See p. 139.

² See p. 77.

made in the three prior 5-year periods from 1960 to 1974 which ranged from an annual average of \$91 million to \$103 million in 1972 constant dollars.

Despite this recent increase in capital outlays we do not believe the VA has yet reversed the gradual functional obsolescence of the facilities. The Department of Medicine and Surgery has developed a system that identifies medical facilities most in need of renovation and replacement.

These facilities are reviewed annually and ones selected are included in a 5-year construction plan. VA's 5-year plan incorporates all proposed major construction projects over \$2 million. This represents 247 projects with an estimated construction cost of \$4,130,000. The VA also has minor project programs for construction and alteration under \$2 million.

Now, the reason for reading those four paragraphs and focusing on this discussion of capital budgeting gets back to my earlier question about looking at the 10-year analysis of veterans medical facilities and their needs in terms of the obsolescence of facilities, the deterioration of facilities, the replacement of facilities, the renewal and rehabilitation of facilities.

I'm very concerned about the dollars that we will have available under everyone's scenario. Whether it's limited Federal dollars or even if the Federal dollars are a little more significant because changes in budgetary policy are going to be inadequate to meet the medical and health care needs of veterans.

I also think that we're going to have to think of some imaginative new ways of funding some of these replacement hospitals. Bill Klinger, a Republican from Pennsylvania, and I indicated to the President of the United States the need to look at the capital budgeting concept.

Has your agency done any review of that concept and requested dialog with OMB to see if there are some new ways of fundings these replacements of obsolete facilities?

Mr. NIMMO. We have not up to this point, but I think it is a thoughtful proposal and we certainly will be eager to engage in conversation with OMB and with you or whomever on that concept.

Mr. EDGAR. I would appreciate that. Both the Speaker of the House and Congressman Jack Kemp signed that letter to the President on the capital budgeting idea so it's not a partisan issue, per se. It's an issue of saying how can the Federal Government do a better job of replacing it's aging infrastructure over time?

Let me take an additional couple minutes and ask you some questions that have been prepared for today's hearings and then I'll yield to my colleague, Mr. Mica and then again to Mr. Smith of Alabama.

Mr. Administrator, we're delighted with your statement in reference to mainstreaming. I want you to know that I agree with you when you say that the VA health care delivery system is already in the mainstream of American medicine and at the cutting edge of quality health care.

I also agree with you that those who call for mainstreaming in the VA medical health care system possess little understanding of the VA health care system.

I hope we can put that issue to rest. Your decision announced on February 19, 1981, to conduct a comprehensive review of construction projects for fiscal years 1984 and beyond was in your words, to insure that those projects are fully responsive to veterans health

care needs, appropriately sized, scoped and located and based on valid workload data and accurate space and functional criteria.

What led you to conclude that existing planning criteria was faulty?

Mr. NIMMO. Again, Mr. Chairman, I found by my personal examination of a number of facilities that there were inadequacies of design. There was, in some cases, overdesign, overbuilding. We found that we were unable to adequately respond to the requirements of Senator Garn's subcommittee for demographic and other criteria. We found in a number of projects, one of which was a new administration building at Battle Creek, Mich., that was scheduled for an expenditure of \$3.1 million on examination, the Department of Medicine and Surgery concluded that we really did not need that building.

An examination of an ambulatory care addition at Marion, Ill., that was scheduled at a cost of \$11.6 million was found to be unnecessary and the Chief Medical Director concurred in that.

We found that the proposed new clinical administration building at Perry Point, Md., scheduled for a cost of \$1.6 million was not needed.

The GAO report of May 1978, questioned our methodology in determining bed size for new and replacement hospitals. A GAO report in 1981 questioned the ratio that we used to divide the need for VA nursing home care units among medical districts and another GAO report in 1981 asserts that our criteria for determining the number of operating rooms results in excess construction of operating rooms.

So, there's been a variety of findings and reports that have suggested to us that the criteria we were using was not adequate and was really not defensible.

It became apparent that in order to respond to the Congress, to GAO, that we had to come up with some new criteria.

Now, as I mentioned we're in the process of doing that with the MEDIPP process, but that's not going to be on line for at least another year. In the meantime, we think we have to take a look at these projects.

Mr. EDGAR. Have you put the new criteria together yet?

Mr. NIMMO. We are putting it together.

Mr. EDGAR. Will you then publish that in the Federal Register or will it be made available to people to review the new criteria?

Mr. NIMMO. I think I should probably respond to that question for the record, Mr. Chairman.¹

Mr. EDGAR. I think it's important that we understand what that criteria is and I appreciate your responding and giving that for the record. I know there are a number of members of this committee who would be interested in what that criteria would be and how it would be outlined in your mind.

You stated that on February 1, you established a top level VA facility planning and construction committee to review the policy options and to analyze and recommend refinements and improvements in the agency's planning and construction procedures.

¹ See p. 77.

You indicated that some members of the committee will also serve as a steering committee for your revalidation of future construction projects.

Briefly, could you provide us with the names of each of the members of that committee and outline for us the reasons each was chosen?

Mr. NIMMO. That is the Facilities Planning and Construction Committee, Mr. Chairman?

Mr. EDGAR. That's correct.

Mr. NIMMO. Yes, that committee is under the chairmanship of the Deputy Administrator, Mr. Hagel. The vice chairman is Mr. Sullivan, seated to my left. Other members are Paul Banai, who is the Chief, Memorial Affairs Director; Ray Blunt, Assistant Deputy Administrator for Program Planning and Evaluation; Clyde Cook, Assistant Deputy Administrator for Procurement and Supply.

Dr. Donald Custis is the Chief Medical Director; Conrad Hoffman, Assistant Deputy Administrator for Budget and Finance; William Salmond, Assistant Deputy Administrator for Construction; Dorothy Starbuck, Chief Benefits Director; Fielding Cochran, Associate Deputy Administrator for Congressional and Public Affairs; and an ex officio member, John Murphy, general counsel.

Robert Schultz, Assistant Deputy Administrator for Reports and Statistics; Joseph Mancias, Assistant Deputy Administrator for Public and Consumer Affairs; and Gregory McGowen, Executive Assistant to the Deputy Administrator.

Mr. EDGAR. It's quite a group of people and it would be helpful if you could provide for the record those who were chosen that have some medical experience.¹

It seems to me that you're selecting some really good people, but they may not have the adequate training, scope, location, and size in experience in medical and health care facilities.

I know that some of your medical personnel would have that, but it seems to me that in listing the names of a very good group of people who would be serving on the committee, that they may be a little bit weak in the area of health care and health care delivery issues.

Mr. NIMMO. Mr. Chairman, what I was seeking, was a broad array of people with management experience, people who have long experience within the agency who have a sense of history about what has transpired before as well as the fresh look that the new people in the agency will bring.

I appreciate your concern about the degree of input in there from medical professionals and we'll be pleased to respond to that.

Mr. EDGAR. What will be the life of the committee? Will it be a permanent body?

Mr. NIMMO. We're not certain of that at this time, Mr. Chairman. First of all, we have the urgent process of revalidation to go through. Whether or not, after that is over, there is a continuing need for that committee, we're not sure yet.

I think there has to be some kind of a formal body established for a continuing review process. But whether it will be this committee or something smaller, we're not sure.

¹ See p. 134.

Mr. EDGAR. I note that Manny Lawton is a member of the committee. Can you tell us who he is, his background, and what his qualifications are that enable him to be a member of the committee?

Mr. NIMMO. Manny Lawton is not a member of the committee, Mr. Chairman. He is one employee among many. I cannot respond to his specific duties but perhaps Mr. Hagel, who is chairman of the committee, could do that.

Mr. EDGAR. He's not a member of the committee? He's staff to the committee?

Mr. HAGEL. I'll explain it, Mr. Edgar. He is the service organization's liaison officer with this construction committee. His responsibilities are directly involved with advising the service organizations which are part of this revalidation process of the time for meetings and receiving their direct inputs. He is the person they can call and they can rely on for information but he is not a member of the committee.

Mr. EDGAR. What is the relationship between the Facilities Planning and Construction Committee and the Revalidation Steering Committee? Is it just a part of it?

Mr. HAGEL. The Steering Committee of the Facilities Planning Construction Committee consists of six individuals—myself, the general counsel, the Associate Deputy Administrator for Logistics, the Assistant Deputy Administrator for Construction, the Chief Medical Director, and the Assistant Deputy Administrator for Budget and Finance.

Those six individuals—five of the six, incidentally, have concurrent responsibility in the process of all construction projects and I am the only individual who has no concurrent responsibility—will be the main thrust in the revalidation process.

It might be useful, Mr. Edgar, if I briefly explain the process that we will use. The revalidation teams are now at work. They initiated the first steps in revalidating 56 projects that were under consideration. By the end of April we hope to have the Central Office's validation part of this project completed. During May and June, we will use these months as the onsite validation processes where if we find projects of the 56 that we think need further justification and the teams will go out to the individual sites to take a firsthand look.

After that is completed, the validation teams which will be under the direction of Dr. David West, executive director of this committee. We have hired Dr. West on a 12-month leave of absence from the Hospital Corporation of America, he will coordinate all those statistics and all the packages for those 56 projects.

Those projects found by the team to have the justification and are revalidated then go to the Chief Medical Director where he and his staff will prioritize them.

After that is completed, those prioritized projects will go to the six-member steering committee which the Chief Medical Director is a member. Within that committee, recommendations are made which will be forwarded to the Administrator. The Chief Medical Director has every option and every right to contest any findings of the steering committee.

There will be no voting. If there is an individual on the six-member steering committee that does not concur with the validation of a project, then that validation or that project would just not be concurred on by that individual.

The question still remains: What do we do with projects that we cannot validate or justify? If that happens, and the validation teams come back with figures that they can't justify, those projects will then be given to the Assistant Deputy Administrator for Construction and the Chief Director for review so that we have another look at the projects.

If the Chief Medical Director and the Assistant Deputy Administrator for Construction agree or disagree on that recommendation by the validation team, then it will be moved into the validated projects we will have to take another look at it.

Mr. EDGAR. If the gentleman would yield?

The reason for asking the question about Mr. Lawton is that you sent a letter to Sonny Montgomery, listing the members of the committee.

And I have in front of me the list of the committee and his name is at the bottom. Is that a misprint, a typographical error and should not be there?

Mr. HAGEL. It is a misprint. In fact, there were a number of people that we had originally scheduled to serve on that committee—the Inspector General was one as you might know—and I don't know if that letter includes the Inspector General, but we have subsequently reviewed some of those decisions and modified them.

Mr. EDGAR. The confusion is a difficult thing to have at this point. Because this letter that you sent and signed, dated March 19, 1982, is not too long ago. And it was sent to our chairman listing out the members. Would you provide us with an updated list, an accurate list of the members of the committee? And also, list those and I understand the Administrator's concern about management, I think that's a good concern, particularly in looking at the whole concept of construction and getting some managers there.¹

But could you star those members that have had some experience in medical and health care facilities because that's been a concern for some?

Mr. HAGEL. Yes. Let me add a few things. Mr. Sullivan has a letter in his possession which he will give to the Chief Counsel of this committee which does exactly what you asked us to do after this hearing. It establishes the new members of the committee and the steering committee and gives reasons for each of those.

I might also add that last week, along with Mr. Sullivan, we briefed members of this committee's staff and the Senate committee staff and we, at that time laid out an updated version of that letter that was sent to the chairman.

Mr. EDGAR. It's tough to get it too updated because it's only April 1 and that was March 19. Two other things very quickly.

One is section 4101-A, title 38 of United States Code provides that there be in the agency a Department of Medicine and Surgery to be operated under the Chief Medical Director. The primary func-

¹ See p. 134.

tion of the Department shall be to provide a complete medical and hospital service.

Section 4102-A-1 of title 38 provides that the Chief Medical Director shall be the chief of the Department of Medicine and Surgery and shall be directly responsible to the Administrator for the operation of the Department.

Under the new system, the Chief Medical Director will be but one voice among many in the decisionmaking process of your new revalidation committee and this new decisionmaking process.

It would be helpful for us to know if you sought any advice or opinion from your chief counsel as to whether or not the creation of this new committee for final decisions on various medical construction projects is in conflict with the statutory provisions of that law.

And also, it would be helpful to know whether or not the House Veterans' Affairs Committee will be kept in touch with the decisions of that committee in light of our move to have you produce this 5-year construction plan to give us full opportunity to review those.

Mr. HAGEL. Mr. Edgar, if I might respond to two of the points? First, we are not displacing the Chief Medical Director as the medical authority within the Veterans' Administration.

This process is not intended to do that, and we had no intention of that when we formed this committee. We will keep the House committee and committee staff advised of the results of this revalidation process and I think that I mentioned this point in the briefings that I gave the staff last week. We will on every step along the way let the committee know where we are and where we are going.

Mr. EDGAR. Thank you. Congressman Daschle?

Mr. DASCHLE. I apologize for my sporadic attendance this morning. I'm in a pretty important markup in the Agriculture Committee as well, but I commend you and the committee for holding these hearings, because I think it's dealing with an issue that is of great import. I want to join with all the members in welcoming Mr. Nimmo this morning.

You stated that construction for fire and safety and seismic related construction scheduled after 1983 will not be delayed and I applaud you for that.

I want to point out some deficiencies which currently exist just in one VA center in Sioux Falls that I think points out the need to emphasize your determination not to delay.

First, the fire exit for the major portion of the first floor passes through the radiology examination room.

Second, there is no external fire escape for the upper two floors of the nursing home. The nursing home does not have an external fire escape. It's attached to the hospital and a single elevator which is hydraulically operated and is consistently, you could say, broken down in the extremely hot weather we have there in the summer.

There are all types of equipment stored in the hallways right now. I was out there again recently and equipment is blocking fire escape routes, simply because we have no storage space.

In addition to the above items that I've talked about, fire hazards are prevalent all over the place. We have patients right now who can't go to bed without first closing the door which abuts their bed.

We have no facilities for isolating patients right now with contagious diseases. We have sterilized equipment stored in the hallways which certainly isn't very hygienic.

That's the problem we have just in one facility and as I go around the country in as limited a fashion as I do, I find this to be more than just an isolated example.

Well, this facility was built in 1946 and not since 1946 have we had one major renovation of any consequence. When I first came to Congress, the project was scheduled for fiscal year 1982 and a few years ago it was moved to fiscal year 1983. And now the VA has moved it to fiscal year 1984 with a revalidation process which could delay it even further.

So, we've seen projects like this. Dire need projects that are being stalled and stalled and put off for budgetary or whatever reasons with extraordinary hazards to the patients.

All it will take is one fire, one huge incident somewhere and the whole world is going to come crashing down on the system. We have been living on borrowed time for a very long period of time.

Now, according to VA Central Office standards, this hospital has insufficient space for radiology, nuclear services, pharmacy, rehabilitation, dental space, supply processing, eye, ear, nose, and throat clinic, ambulatory services, and we have patients waiting in the hallways for outpatient services.

I give you that background because I was astounded to hear about what the Inspection General had to say. The Inspection General came out, looked it all over and said that even though a reduced size clinic of \$15 million was being considered right now, they didn't think it should be built. They didn't think there was any need for it.

I was astounded to learn of that kind of a report. I want to cite an example that I picked up in Oklahoma. I've learned that the team captain on the Muskogee team review had only been at the VA for 3 months. And three out of the four remaining team members had never set foot in a VA hospital or had experience with private health care facilities.

That's the kind of Inspector General teams we're sending out right now. And they're telling us on the basis of that limited experience, that there is absolutely no need for some of these facilities.

I mean you don't have to be an Inspector General to realize that when you're blocking fire escape routes, when you've got storage in the hallways, when you don't have an exterior fire escape, that we've got very serious problems.

The question I want to ask, after having said all that is how do you, as the Director, insure, right now, that individuals conducting these audits have the proper background in hospital and medical planning?

Have you given any attention to what appears to be some very serious deficiencies here?

Mr. NIMMO. You're talking, Congressman Daschle, about the—

Mr. DASCHLE. The Inspectors General themselves.

Mr. NIMMO. Well, the Inspector General, as I'm sure you realize, is essentially independent within the agency. He is a Presidential appointee, but responsive basically to the Congress. I would say that Mr. Sato and I have a very good relationship and I have a

high regard for his ability. But as far as the people he selects to conduct audits or whatever function he assigns them, he has the total responsibility in that area without direction or influence from me.

Mr. DASCHLE. I would like to pursue this line of questioning but I see my time is up, Mr. Chairman, and I would like a second round when the time comes.

Mr. EDGAR. The gentleman will get a second round and also can submit any questions for the record that he wishes.

Congressman Mica?

Mr. MICA. Thank you, Mr. Chairman. First, before we proceed, I would like to submit just for the record, a memo signed by Tom Doherty, director of the VA hospital in Miami.

Mr. EDGAR. Without objection, so ordered.

[The memo referred to follows:]

A MESSAGE TO VETERANS RECEIVING CARE FOR NON-SERVICE-CONNECTED CONDITIONS

The Veteran population in the State of Florida continues to grow at a staggering pace. As a result the services the VA Medical Center, Miami, provides are being taxed beyond its resources. It is therefore necessary that we curtail outpatient services to non-service-connected veterans who are not legally entitled to priority outpatient treatment on a continuing basis and to service-connected veterans rated less than 50 percent who need outpatient services for non-service-connected conditions. We are therefore implementing the following policy change.

Upon your admission to the hospital or outpatient treatment program we will immediately begin your predischARGE planning. After discharge from the hospital, if follow-up treatment is indicated, you will normally be expected to receive this treatment from your private physician at your own expense. If our physician staff determines that follow-up treatment is indicated by the VA you may be placed on a treatment program not to exceed 6 months duration. At this time you will be discharged from the program or referred to your private physician at your own expense. If you do not have a private physician you may elect to see a social worker who will assist you in locating the appropriate community resource for continuation of care. The same time limitation for outpatient treatment will apply to veterans who are placed in the Ambulatory care program; obviate the need for hospitalization.

We regret that this action is necessary; however, if we are to continue to provide the highest quality of care to the veterans we serve, these still are required.

T. C. DOHERTY, *Director.*

Mr. MICA. I might indicate that I have provided a copy to counsel.

Dr. JACOBY. Mr. Mica, if I could? I would want to clear one point.

Mr. MICA. I was about to say, it is my understanding from our own counsel that it is reasonable. There is no question, as to the nonservice criteria.

Dr. JACOBY. My point is that, patients who have a service-connected disability have first priority, and they always will, all across the entire system.

What Mr. Doherty had put out is that the service-connected veterans rated less than 50 percent who need services for non-service-connected conditions and, therefore, they are put in a different priority.

Mr. MICA. I accept that. I don't accept the fact that Florida is the only place that this is going on, but apparently it is.

I would like to know if you can submit for the record any other places where this criteria is in effect outside of Florida. In fact, I

understand that it is informally in effect throughout a good portion of Florida.

[Subsequently, the Veterans' Administration furnished the following information:]

All facilities, including those in Florida, report that they are continuing to treat service-connected veterans with ratings of less than 50 percent and have not published or handed out information locally to the contrary. There is no informal policy to the contrary in the State of Florida.

Mr. MICA. That situation is then compounded, if it's legal. I don't understand the legality. It's only being done in one place and we're heavily impacted. What can we do about it?

I will not argue the legality, but I will say that I really would like to see some way to do something about it now. That brings to mind this study.

I was pleased to initiate the request for this study when I first came on the Veterans' Affairs Committee. Let's just say that should we need a new VA hospital and/or an outpatient clinic somewhere in the State, how soon could we have something on line? Of course, I know what the answer is.

Dr. JACOBY. I think the answer would probably be "just as soon as possible," if we could establish the requirements. It's about 8 or 10 years in construction. That would be the case. Now, obviously in the case of Pensacola, that was not a problem. I believe that this process is now probably about a year and a half or 2 years at best, if instead of going to construction, we go to leasing. Therefore, we can shorten the process once it is established.

Mr. SALMOND was, of course, very interested in this particular area but I am unable to add any further comment.

Mr. MICA. That's the point that I am working on. I would invite you to check the figures that I am giving you because they were given to me by the VA in Florida. The Miami clinic, the very clinic which put out this memo, the outpatient clinic there was designed, they tell me, for 135 visits a day. They are seeing every day over 1,000 people.

Those figures are not even approachable in any of the studies that I have seen any place else in the Nation. The VA outpatient clinic in my own area, up in Rivera Beach, are far above expectation in business.

The determination of benefits to non-service-connected veterans in Tampa, Gainesville, all over the State, again, are not happening any place else in the country.

What we are seeing here, if the figures that I am giving you are correct, is a phenomenal impact on the system with no potential for relief—not even under the study I requested and I am very proud of that—and I want to see us get some facilities. But can't you contract immediately when you find the need and you want to do something now?

Mr. SALMOND. Mr. Mica, you are aware assuredly that in fiscal year 1982 there was \$49 million appropriated for expansion to the outpatient clinic at Miami.

We are in the working drawing process right now and expect to be under construction in January of 1983.

Mr. MICA. That is the expansion of a clinic that was designed, as I said, for 135 people a day. There is supposed to be 1,000 a day. They are now seeing 1,000 a day. I don't have the exact figures, but when I was there our projections indicated that when the expansion is finished it will still be behind.

The new facility in Broward County is already expected to exceed this year's projection. Let me just give you one aside. This is not just VA. I mean, most post offices are out of date, our IRS, the social security offices.

My district has over a million people in it and there are districts on either side of me that should be served so we recognize that it is a Government-wide problem. We're talking about health care for veterans.

We can wait. People will stand in line at the post office for postage. Some of them love to stand in line with their IRS forms and use that as an excuse.

I think it deserves some attention now and it is not a situation where it is happening all over the country as a result of budget cuts. It is happening because of massive migration.

I'd like you to check my figures. They told me when I came here, the 5,000 a month that I used, that for every single month from the day I came to Congress, we had to have 5,000 a month and it has never fallen below that in the last 36 straight months. In addition, Florida has grown a resident veteran population.

All that adds up to what I think is a reason for contracting for some assistance to ease that burden very rapidly.

Dr. JACOBY. In answer to your question, can we contract, we need to clarify what we are contracting. If we are contracting for medical care, obviously the service-connected veteran is entitled to care. If it is contracting for facilities, then if needs are developed, then it is not only a matter of getting space, it is obvious that it is a matter of the additional resources to provide that care.

Obviously, we will look at every means available to us and within the resources that we have in order to satisfy the requirements to accomplish our mission.

Mr. MICA. I see that my time is up. I would just like to add one more point in contention for our need for immediate action. Again, they are your own figures. While the veteran population nationwide is going to go down 10 percent in the next 15 years, Florida's is expected to increase 100 percent.

The population over the age of 65 is expected to increase by a minimum of 570 percent, and it is my understanding that VA records indicate that that population needs four times the care as the population under that age group.

So, if you take a disaster and add a catastrophe on top of it, and put a crisis right in with it, that is a situation we are facing right now in Florida because the elderly population in my own district is 34 percent of the whole district, not just veterans. Thirty four percent is over the age of 65. So, all of this adds to the urgency.

Many of the veterans say, "Why even wait for the study until October?" I understand we need a logical, reasonable approach to this but in the meantime we have people standing out—I think the Administrator saw them today—they were standing in line in the sun, waiting for care. That's how difficult it is getting.

One visit to any of the outpatient clinics down there would back up what I have said.

Thank you, Mr. Chairman.

Mr. EDGAR. And it's raining in Miami this morning.

Mr. Smith of Alabama.

Mr. ALBERT LEE SMITH. Thank you, Mr. Chairman.

I have one followup question. On the question of building the new facility in Minneapolis. Even if the money was included in the budget, is it possible that with revision of blueprints, it might not be able to award the project in fiscal year 1983 and have it started in 1983?

Mr. NIMMO. That is correct. My understanding is that we could do some site development, is that correct?

Mr. SALMOND. It's only site development, sir. It's a minimum amount of work. It probably isn't going to run more than about \$4 million.

And we have that money available within the \$15 million that's already been appropriated.

Mr. ALBERT LEE SMITH. But my question is whether the construction would be able to start in 1983?

Mr. NIMMO. Not on the structure itself. No, sir.

Mr. ALBERT LEE SMITH. Thank you. Thank you, Mr. Chairman.

Mr. EDGAR. Mr. Administrator, we still have some more questions so I hope you'll be patient and if anyone has to leave and come back, please feel free to do so.

Let me ask you some specific questions about a GAO report. In December 30, 1981, in a report to this committee, the GAO suggested that Congress consider allowing you, as Administrator, to extend your advance planning fund to cover final design work. The General Accounting Office concluded that this would shorten the design and construction process and thus reduce the effect of inflation on the project cost.

However, the General Accounting Office also concluded that our decision on whether to allow this change would rest largely on the confidence we have in your ability to identify and prioritize its construction requirements.

Two questions. What is your reaction to the GAO suggestion and second, do you plan to request a change in the authorizing language necessary to extend the advance planning funds?

Mr. NIMMO. If I may, Mr. Chairman, I'd like to respond for the record.

[The VA subsequently supplied the following information:]

GAO's findings on the design funding issue are presently under consideration within the agency; however, a final position on the issue has not yet been developed. If the design fund is supported by the agency, coordination with OMB will be required prior to an actual request for funding.

Mr. EDGAR. If you would, I'll submit all of the questions that relate to the General Accounting Office report to you. They made some helpful suggestions and I hope that you could respond for the record to those projects.

Also, for the record, I'd like to include a letter that you sent me in response to a letter that Congressman Hillis and I and others requested of you dealing with the project in Indiana.¹

Let me ask you a couple of questions about that project.

This subcommittee held hearings in Gary, Ind., on November 30, 1981, on the need for and justification of establishing an outpatient clinic in northwest Indiana. We learned at that hearing, that the medical needs of 168,000 veterans in northwest Indiana are not being adequately met by the Veterans' Administration.

While there were 14,000 staff visits by northwest Indiana veterans to the Chicago areas of veterans hospitals, the VA estimates that more than 50,000 veterans would be qualified to seek medical assistance at a northwest Indiana outpatient clinic.

Do you agree that some sort of an outpatient facility is needed in northwest Indiana to meet the health care needs of these veterans?

Mr. NIMMO. We will, with your permission, Mr. Chairman, respond for the record to that question.²

Mr. EDGAR. I have a little bit of a problem with responding for the record, because the letter that I received, and I know you signed the letter and it was written by your staff, was a little bit inadequate to the questions that were raised in our earlier question. And I understand you want to hold off making any substantive comments about certain projects until you do a reevaluation.

But this suggests that not only are you not going to move for an interim facility, but you're going to wait until after January of 1983 to make any kind of interim decision on this particular project.

A number of Members including other members of this committee traveled to Indiana and became very strongly convinced that some interim solutions should be developed before we move to a longer, more permanent clinic or another kind of facility there.

Do you have any idea as to how long it will take to respond for the record?

Mr. NIMMO. Before the end of next week, Mr. Chairman.

Mr. EDGAR. Thank you. That would be timely and helpful. You had indicated once before that a study was going to be done about this facility. It would be also helpful if you could make available to this committee a copy of that study and we'll submit several additional questions for the record.

Let me ask you a couple specific questions about Philadelphia. I would like to ask unanimous consent to include in the record the National Veterans' Affairs Rehabilitation Commission of the American Legion's visitation report on the Veterans' Administration Medical Center in Philadelphia.³

We'll put that in the record and on page 15 and 16 of that document, several recommendations were listed out. Let me ask you a couple of specific questions.

The VA 5-year construction plan includes \$25 million for clinical improvements for the VA hospital in Philadelphia.

¹ See p. 79.

² See p. 145.

³ See p. 80.

I do not see that project listed in the document nor did I see this project listed in your February 26 memorandum on the fiscal 1984 construction format.

What is the status of the \$25 million clinical improvements for Philadelphia?

Mr. SALMOND. We have an architect who is developing concepts to solve the multiple problems that we have in Philadelphia.

Mr. EDGAR. Is the \$25 million on hold?

Mr. SALMOND. No, sir. We're working with the architect and when we get his concepts, we will then be working with D.M. & S. to make some sort of a selection. And we would be working with Mr. Nimmo to see which way he would wish to go.

We can proceed then in the advanced planning process to develop the preliminary plans so that we can come into a future fiscal year budget.

Mr. EDGAR. We have just completed a review, that I have submitted for the record,¹ by the American Legion National Affairs Rehabilitation Commission which states the following:

Space deficiencies were in evidence in virtually every patient treatment service. The proposed clinical addition would eliminate the major concern pertaining to insufficient space and they underscore the need to make sure that those \$25 million are available to be expended once the architect designs are completed.

Mr. SALMOND. We're not sure just what the cost of the project is. The \$25 million is a magnitude estimate from a number of years ago. It's a guesstimate.

Mr. EDGAR. I agree. In discussions at the hospital and in discussions with some of the medical people on your staff, Mr. Administrator, \$25 million probably was not adequate.

We also discussed the possibility of a replacement hospital using the existing facility for nursing home care and outpatient clinic and perhaps, moving to a replacement hospital.

It becomes a little bit of a "Catch-22" in this discussion because as much as we want to protect the \$25 million so it doesn't evaporate at some point, we also want careful consideration for what is the most viable alternative, given the fact that we are not building the Camden facility and the actual acute care bed needs for the Philadelphia metropolitan area is larger than the actual number of beds available at the Philadelphia facility.

And there is a little bit of fear on the part of some of the veterans in our area as to the fact that if we jump from a rehabilitation project to a replacement hospital project, we move from \$25 million to whatever a figure is necessary for a replacement hospital.

That given the time that Dr. Jacoby and others have said it takes to have a replacement hospital, some necessary renovations may not be taking place at the present facility as we await the shopping list and the long lead time that it takes to put in a replacement hospital.

It's 1982, it takes 10 years to put a replacement hospital in place. If that were the decision, that's 1992. The hospital was built in 1952, so it would be a 40-year-old hospital in need of some renovations and some changes.

¹ See p. 80.

There may be an interim suggestion. That interim suggestion could go in a number of ways, one of which could be that a sum, whether it's \$25 million, could be used for renovation in the short-term to make the hospital more adequate for quality care. And those same renovations could lend toward use of that facility for outpatient or for intermediate care in terms of a nursing facility.

So, that we would move at that front, at the same time, we were moving on the front of seeing how dollars would be made available at some time in the future for a replacement hospital.

I share it with you more as a conscientious concern voiced by many veterans in the area and voiced by some who fear that if decisions are made to move for replacement some of those dollars will be lost.

Do you share that concern or do you think everything is in place to keep an eye on all of those possible options?

Mr. NIMMO. We do share that concern but again, Mr. Chairman, we hope and expect that through the MEDIPP process that those requirements and those options will be presented to us.

Mr. EDGAR. Let me ask you a specific question. There's an on-going construction project being managed in-house, at the Philadelphia hospital. There's an excellent engineering staff and they're doing their own in-house work. I think it's probably the most effective way to get the work done.

Funds have already been allocated for the project in-house, but the hospital does not have sufficient ceiling in its FTEE or man-months to complete the project.

What is the status of the request to free-up the hospital to move in-house with this present construction process and lift the ceiling of the FTEE?

Mr. NIMMO. We would like Richard Falco, Deputy Director of Facilities Planning and Construction to comment on that.

Mr. FALCO. We are aware of the problem in Philadelphia which resulted from the budget adjustments we made in meeting the 1982 budget. As part of the 1982 budget revision we've had to reduce ceilings in the agency. Some of the ceilings we reduced fell into the area of these "purchase and hire" employees.

We are trying to reconcile some ceilings situations within the agency so that we can give relief to the Philadelphia hospitals. If we are unsuccessful, if the administrative procedures don't allow us to bring the ceiling forward, then the hospital would have to move to contracting out in lieu of completing the work with "purchase and hire".

We're optimistic about making some internal shifts within the ceiling of the agency to get relief in Philadelphia.

Mr. EDGAR. I'd appreciate it if you would keep your eye on that and continue to pursue it and hopefully give that administrative relief as soon as possible, because contracting out at this point would be an expensive process. It would delay the work and we think we can do it in-house and have it done in a much more expeditious way.

We really appreciate your working on that project.

I'd like to yield to my colleague, Mr. Daschle.

Mr. DASCHLE. Thank you, Mr. Chairman.

I want to follow up as we were talking earlier about the Inspector General. I understand, Mr. Nimmo, that you have little immediate jurisdiction over the Inspector General and I'm going to ask the I.G. to come up in a moment.

But before I do, I would like to pursue some questions with you. I'd like to know what value do you give these reports?

How do they factor into the overall interpretation of the need for a given project? Where does the report fit in? Does it have, or is it tantamount, to a veto if the I.G. says you can't build it? Tell me about it.

Mr. NIMMO. No, Mr. Daschle. We never have enough facts on which to base a decision. They are subjective judgments at best. I read the reports carefully, ask lots of questions, and balance those reports against the information that the Chief Medical Director gives me. Then I make a decision.

Mr. DASCHLE. How do you rank the D.M. & S. and the Office of Construction recommendations in terms of weight?

Mr. NIMMO. I would not say that in any given instance I give x amount of weight to that. I've been making management decisions in Government for almost 40 years and every case is a little bit different.

And you just have to look at all of the facts you can put together and make the very best judgment decision you can on that basis. In one instance, you may give more weight to it than you would in another.

Mr. DASCHLE. What is your view of the I.G. inspection reports that you have been getting about some of these construction sites? Or I should say prospective construction sites?

Mr. NIMMO. The reports, of course, are put together—the pick-and-shovel work, as it is done by different people.

In general I regard the reports as useful and reliable.

Mr. DASCHLE. How often do you find disagreement between the IG report and the recommendations of D.M. & S. and Office of Construction?

Mr. NIMMO. To be perfectly candid, there are disagreements as there ought to be.

Mr. DASCHLE. Would you term the disagreements frequent or infrequent?

Mr. NIMMO. Everything is relative. I would not characterize them as infrequent nor would I want to characterize them as frequent. There are disagreements from time to time.

Mr. DASCHLE. Numerous disagreements?

Mr. NIMMO. We have 172 hospitals. I believe we have a lot of reports, so needless to say, there are numerous agreements.

Mr. DASCHLE. All right. If we find numerous disagreements, you, as the Administrator, must make a decision based on information before you. I'm still trying to get a better perception of how decisions are made. As a rule, now, I understand there are exceptions, but as a rule, do you look upon D.M. & S. and the office of construction with a little more weight given the fact that they are induced on a day-to-day basis?

Mr. NIMMO. Let me explain it this way, Mr. Daschle. I would be pleased to have Dr. Jacoby correct me if I am wrong, but I cannot recall one instance since I've been Administrator in which I have

overruled the Department of Medicine and Surgery based upon a finding by the I.G.

I have looked at the I.G. reports. We have canceled some projects when the findings or the recommendations were concurred with by the Chief Medical Director. I can recall no instance in which I have taken the I.G.'s recommendations over the objections of the Chief Medical Director.

Mr. DASCHLE. That's encouraging. I am glad to hear that.

I was interested in your letter to Senator Cranston some months ago when you—I'm going to quote a paragraph that my staff has provided me. My staff tells me and I have to tell you since I haven't seen the letter, but correct me if I'm not quoting you right.

You were talking about the revalidation process for VA construction projects and the quote cited there is:

The basis for my decision (to start at this time) were several. First, revalidating projects already approved and funded for construction by Congress could have resulted in delay of needed medical care facilities, subsequent increased costs and in some instances, possible contractual liabilities.

Is that roughly the statement that you made?

Mr. NIMMO. If you are reading from the letter, I have to assume that it is.

Mr. DASCHLE. OK. I applaud that. I think that's excellent, but I'm confused—I was in Muskogee a while back and I had an excellent discussion with some VA people there and Congressman Synar, I'm told that even though funds have already been appropriated for the Muskogee site and are in the working, drawing stages, the I.G. came out and said, "stop the funding." Contrary to what you've said in the letter, it appears, anyway, that you have now stopped the funding. I see Mr. Sullivan nodding his head "no."

Mr. SULLIVAN. That's not at all the case.

Mr. DASCHLE. Tell me what is.

Mr. SULLIVAN. It's proceeding right along through the working drawing design and we expect to start construction in January of next year.

There's been no attempt whatever to stop the project. In fact, we've seen no reports and no word has come through us at all as to what's gone on in Muskogee.

Mr. DASCHLE. So, as far as you're concerned the construction in Muskogee is on track?

Mr. SULLIVAN. Absolutely. The architect is doing his work.

Mr. DASCHLE. You have not even seen the I.G. report?

Mr. SULLIVAN. No, I have not. As I understand it, and the I.G. is here and can clarify, the audit team was just out there.

Mr. DASCHLE. Who calls the audit team out? Who directs the audit team to go to Muskogee or to Sioux Falls or to Philadelphia?

Mr. NIMMO. Ordinarily that is done by the Inspector General. Now, there are instances in which I asked the I.G. to look into a particular situation or go to a certain specific facility.

But generally speaking, those visits, those areas of audit are determined by the Inspector General.

Mr. DASCHLE. This has been very helpful to me. But, I'm confused on why if we've already appropriated money, authorized construction, approved the architectural drawings—why in the world

do we send an I.G. out there to determine the feasibility of the project? I will ask the I.G. this in just a moment.

And one more question, Mr. Nimmo, regarding a very parochial interest. I understand that the approval for the regional office in Sioux Falls is on your desk and I'm wondering what you're going to do about it.

Mr. NIMMO. When I come to it in the file, Mr. Daschle, I will make a decision. I haven't made it yet.

Mr. DASCHLE. You are familiar with the project.

Mr. NIMMO. I would not say that I'm familiar in any specific way with it.

Mr. DASCHLE. Can any of your staff help clarify that question?

Mr. SALMOND. The project is not on his desk, sir. It hasn't reached there yet. We still have an additional piece of work to do.

Mr. DASCHLE. What needs to be done?

Mr. SALMOND. An A-104 study which is a rent or build study.

Mr. DASCHLE. How long will that take?

Mr. SALMOND. That shouldn't take too long.

Mr. DASCHLE. Too long is how long?

Mr. SALMOND. A couple of weeks.

Mr. DASCHLE. So, it will be on his desk by summer?

Mr. SALMOND. By summer? Oh, yes. Earlier than that. I hope.

Mr. DASCHLE. Can you contact me just as soon as you make a decision; right?

Mr. SALMOND Yes.

Mr. DASCHLE. Is it Mr. Sato? Mr. Chairman, could I ask the consent of the committee to ask Mr. Sato a couple of questions?

Mr. EDGAR. Without objection.

Mr. DASCHLE. Mr. Sato, initially let me get back to the question that I directed to Mr. Nimmo. In regard to why would an Inspector General send an audit team out to a site already under construction or already designated for construction, I thought the audits were to determine whether or not construction should be implemented.

Mr. SATO. Let me clarify that, Mr. Daschle. I think that the audit site you referred to is the medical center in Muskogee, Okla.

That visit was a routine, regularly scheduled audit of the medical center. As a part of that audit process, we examine various areas where funds are being expended. The construction project apparently was looked at as a part of the normal installation audit, just as we looked at procurement or financial operations.

Mr. DASCHLE. Can I interrupt for just a moment? I understand that these guys were out there for about 3 weeks or longer. I mean, just an extraordinary amount of time. And what length of time do they usually stay at a facility and was the Muskogee inspection seemingly much longer than what would be normal?

Mr. SATO. I don't know how exactly how long the team was there, but let me just mention that before I joined the VA last summer, the audit teams generally would be on site from 5 to 10 weeks. I've been working to reduce that time element. To clarify your earlier point, the final report of the audit of the Muskogee medical center has not been released. However, there were discussions with the local management officials during and at the completion of the audit.

Following the normal process, the audit team would look over all the results and prepare their draft report, the draft report would then be given to the local officials for their review and comment.

Mr. DASCHLE. Do you know that they told the people in Muskegon that their recommendation would be that that facility not be built.

I think that's an extraordinary thing to tell them if, indeed, it hasn't even been made public and it hasn't been approved by you. I wonder how this system works?

It seems to me we've got a lot of loose ends here. I want to ask you how in the world we find these guys that they have no experience? They're in there for a couple or 3 months and, the other ones have never set foot in a VA hospital and you're telling them to go in and audit a hospital. What kind of training do you give them? And under what circumstances do you give them the right to tell what their recommendations are going to be?

Mr. SATO. Well, you raised a couple of questions.

First of all, I'm not sure that the audit team recommended that the project be stopped. That kind of a recommendation would be made officially in a final report. Other VA witnesses have said here today that an official audit report has not been prepared. In fact, it's my understanding that a draft report has not been prepared. I have not seen it, and there's been no discussion of the audit results at the VA central office management levels.

Mr. DASCHLE. Well, my suggestion to you is that before rumors like that get started, before obviously a great deal of anxiety is created unnecessarily, they be very seriously advised that that isn't a very proper procedure in which to act.

Again, let me get back again to qualifications here. I would like to know what criteria you use in hiring these people? Where do you find them?

Mr. SATO. These folks are audit personnel.

Mr. DASCHLE. Audit personnel. What does that mean?

Mr. SATO. Accounting, auditing background.

Mr. DASCHLE. They have an auditing background?

Mr. EDGAR. If the gentleman would yield?

Mr. DASCHLE. Yes.

Mr. EDGAR. I appreciate the line of questioning and I just feel a little bit of pressure in that the chairman disappears at 12:30 because of a conflict. So, if we could focus the questions here a little bit. We do have a couple of other witnesses that we would like to hear from who have substantive things to share. I hate to cut you off because I talk a lot usually myself.

Mr. DASCHLE. I wasn't aware we had additional witnesses and I apologize.

Mr. EDGAR. That's OK.

Mr. DASCHLE. I would like the Inspector General to submit to the committee for the record the criteria you actually use to select these people and, in your opinion, what, or how do you insure that the information you're getting is accurate? What kind of checks and balances do you have on the inspection procedure?

If you could submit that for the record in the interests of time, I will not pursue any further questions at this time.

Mr. SATO. I'd be happy to do that.

[The Veterans' Administration subsequently supplied the following information:]

Question. What criteria do you actually use to select Inspector General Personnel?

Answer. Inspector General (IG) personnel are primarily audit and management analysis personnel and are selected based primarily on their demonstrated ability to evaluate the complex Federal Government management processes. The IG personnel are not technical persons, i.e., doctors, scientists or engineers, but instead through a combination of formal training and experience have gained the ability to objectively evaluate the process by which technical persons manage agency programs. Their evaluations are then directed at these management processes and not at the technical aspects of a particular program.

Question. What or how do you insure that the information you are getting is accurate?

Answer. Inspector General personnel conduct their audits in accordance with the professional Governmental audit standards set forth in the GAO "Yellow Book." These standards establish the audit procedures to be used in assuring that information obtained in support of the audit conclusions is accurate and relevant. The GAO standards and work done in accordance with these standards closely parallels the standards and work done by management auditors in the private sector.

Question. What kind of checks and balances do you have in the inspection procedure?

Answer. Established Governmental and professional auditing standards require that all audit assignments be properly staffed and supervised. We assure that these standards are complied with through a multilevel supervisory review process both at the field audit site and for substantive assignments at our Central Office. Perhaps more importantly, established standards require that the auditor discuss all factual matters and review observations with the auditee, or program staff, as the review progresses and at its completion. The auditee is requested to submit formal comments, concurrence or nonconcurrence for inclusion in the final audit report. In all cases of nonconcurrence on substantive or sensitive issues, draft reports with the auditee comments are reviewed by senior staff in the Office of Inspector General and are discussed with senior program staff at the VA Central Office before a final report is prepared. In the very few cases where resolution cannot be reached at our respective senior staff levels, unresolved issues are submitted to the Deputy Administrator for resolution.

In the case of our review at the VA Medical Center at Muskogee, our established checks and balances did not have an opportunity to work. The audit team had not prepared a draft report for the Medical Center Director's review and comments. The team is now preparing a draft report. If the Medical Center Director does not concur with the auditors' draft report, and does not present sufficient additional information to change the auditors' observation, the draft report with the director's comments will be submitted to senior staff in my office for review.

Mr. DASCHLE. Thank you. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. I apologize for cutting you off a little bit on that—

Mr. DASCHLE. I'm sorry. I didn't realize we had more witnesses.

Mr. EDGAR. It's a helpful area and we do have a couple more witnesses.

Mr. Administrator, we've talked today about change over the next 10, 15 years in the hospital system. We talk a little bit about your process for analyzing what makes sense to provide quality health care for veterans. We've talked about the fact that they're going to be limited dollars. We're going to be targeting those dollars much more carefully even at a time when the aged veteran may be getting older, is in fact getting older, and may put some extra demands.

We've also talked about the need to have some flexibility for the immigration areas for large population trends as well as the older areas that need rehabilitation. We hope that you also heard a little bit of a feeling that flexibility may be needed within medical deci-

sionmaking processes because different parts of the country have different needs.

I visited the Coatesville, Va., facility a week ago and they were having a couple of little problems with some budget restrictions within their budgetary categories and the inflexibility that they have to live under and not being able to transfer funds from one category to another. And that inflexibility is causing a little bit of a bulge in some areas and zero funding in another.

We've also talked a great deal and you looked at this and we appreciate your focus on the gold-plating of hospitals. I don't think any member of this committee wants to build hospitals that are overdesigned or overconstructed.

I also don't think we want just simply cinderblock warehouses for patients. At the Coatesville facility, I was really pleased to see that a certain amount of funds have been submitted to make the hallways and the areas a little more attractive and a little more humane for persons to be in.

Sometimes some of the architectural designs are to make it more human and the balance between gold-plating facilities and making those facilities livable and humane, I think is important.

Also, with the limitation of funds, there have been some statements that you've made and we haven't had time to talk about them, about the possibility that we may have to restrict or cut eligibility for certain categories of service. We will be asking you additional questions on that in the future and I hope that you will respond to us.

You've been very kind.

One last question. Have you talked to the President yet?

Mr. NIMMO. No, sir, I have not.

Mr. EDGAR. I'm going to ask you that question each time you come. It's important and a number of the veterans groups and others have hopefully requested that more dialog between you and the White House might take place and since we're now moving to a nuclear freeze in reduction, maybe the President will have more time. Not worrying so much about the Russians, he'll have more time to look at the need for veterans and perhaps, you can get on his schedule.

Thank you for your testimony today.

Mr. NIMMO. Thank you, Mr. Chairman.

Mr. EDGAR. Now, we're going to hear from Paralyzed Veterans of America, then the American Legion, the Disabled American Veterans, the Veterans of Foreign Wars and the Amvets. And again, as is my custom, I'd like to apologize for having you sit and listen so long and come into the end of our discussion, but I think it was helpful for you to hear the Administrator's answers to the question.

We appreciate your patience today. We'll begin with Mr. Mansfield and each of you, your full statement will be made a part of the record. We'd appreciate it if you could summarize the cogent and really vital points this morning and get to the heart of your message. And we'll start with the Paralyzed Veterans of America.

**STATEMENT OF GORDON H. MANSFIELD, ASSOCIATE
LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA**

Mr. MANSFIELD. Thank you, Mr. Chairman.

The heart of the message in a few succinct words from the Paralyzed Veterans of America is that after having listened to the testimony, we request that this subcommittee and the full committee continue the excellent oversight—in this area especially.

I believe that the full prepared statement which is in the record points out the reasons for that.

Mr. EDGAR. I appreciate that very concise statement and we will continue and Chairman Mottl is committed to continuing the oversight function and as you could hear from some of our questions, we're nervous about the new process to make sure that our subcommittee does not get cut out of the discussions and the priority setting of that new process.

Mr. MANSFIELD. I would hope also, Mr. Chairman, that the veterans service organizations are not cut out of the process.

[The prepared statement of Mr. Mansfield appears on p. 105.]

Mr. EDGAR. I appreciate that.

Next, we'll hear from Mr. Egan and also, Bob Lyngh.

Before you begin, let me thank you for your site visit to Philadelphia. The American Legion has done an excellent job in their efforts and also I noted in your testimony several paragraphs on the capital budgeting concept.

It is a controversial concept. It will be discussed and fought over at OMB level, as they always fight changes in budgetary processes. But I think it's an idea that's time has come for at least some technical analysis and I appreciate your focus on that.

Mr. LYNCH. I hope you find our remarks in that regard acceptable, Mr. Edgar.

Mr. EDGAR. Very helpful.

STATEMENT OF ROBERT E. LYNCH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. LYNCH. At the outset and before we discuss the details of the Administrator's initiative as we understand it, let us first say for the American Legion that this organization has always supported the concept of tight, cost-effective management by the Veterans' Administration.

At no time since the VA was established have we ever sanctioned the idea of loose, irresponsible management of the agency. Where we have seen problems with management develop we have suggested and supported improvements in management techniques.

Having said that however, we must add that the method chosen by the Administrator to launch this initiative, and the comment attributed to him at that time, as well as other statements recently made by and attributed to him, raise in our minds the question of whether this Administrator does in fact understand the congressionally mandated mission of the VA to provide health care to sick and disabled veterans, to participate in the training of health manpower for the Nation, and to engage in basic research that will ad-

vance the state of medical science for the benefit of the entire American people.

Nothing has happened to change that congressional mandate, and in fact, recent congressional action has broadened the VA's health care mission by making it the principal contingency backup to the medical care program of the Defense Department, so that it now has a fourfold mission.

The 172 hospitals and 225 clinics of the present VA system represent a multibillion dollar capital investment in the most comprehensive health care delivery plant to be found in the Nation, and perhaps in the world.

The fact is that plant is in a deteriorating condition. It includes hospitals built before World War II. It uses buildings some of which were constructed before the turn of the century. Many other of the present structures were built immediately following World War II.

Many of them are more than 30 years old. The changes in medical science and medical technology during these years have been massive.

These older hospitals are simply not configured to adapt to modern medical technology.

Just as one example, in the 1940's and 1950's, there were no such things as intensive care units, there were no dialysis units. The requirements for surgical suites were entirely different than they are now; there are entirely new standards of privacy and space allotments, now mandated by the Joint Commission on the Accreditation of Hospitals.

All of these things have set up basic changes that must be made to enable doctors to practice modern medicine within the VA system. The VA medical care system was first built to accommodate a veteran population of 4 million veterans of World War I.

Following World War II, it was expanded to care for a population enlarged by 14 million and since that time there is an added 5.5 million Korean veterans and now an additional 9.5 million veterans of the Vietnam era.

The result is there are veterans in every part and parcel of this Nation. The fact that they are on the move in a mobile population has not changed that fact.

We have no objection to continuing demographic studies of the veteran population. We will support needed changes in the configuration of the system that are clearly demonstrated.

We reject the implication that the present demographic configuration of the veteran population calls for any move to close any of the hospitals now operating.

In other statements the Administrator either implies or makes reference to new VA facilities. We object to these statements because they are inaccurate. The fact is there are no new facilities planned for the system.

The entire construction program is for renovation and replacement or for correction of space deficiencies in existing facilities and for correction of fire and safety hazards.

The last new hospital in the system was added when the VA medical center at San Antonio went on line in November 1973. With the Administrator's interest in changing demographics, we

hardly think he would challenge the demographic justification for hospitals in that locality.

Let us proceed now for a moment to the implication in the Administrator's statement that the medical construction program is not justified by current criteria of need. We will accept the possibility the present system of validation can be improved and we will support changes to effect improvement. But the present system, as we understand it, is projected from the 5-year plan developed by each hospital in the system.

Construction needs identified in the 5-year plan of each hospital are reviewed by central office and if approved, find their way into the 5-year plan submitted to Congress by the agency.

Construction recommendations submitted to Congress are subjected to oversight considerations by the Veterans' Affairs Committees of both houses and also studied for approval by the Appropriations Committees.

It is a fact that many changes, including deletions, result from these congressional studies. Is the Administrator implying then that the congressional committees are not doing their job? We believe the subcommittee is entitled to an answer to that question.

We proceed to observations about the procedures established by the Administrator to implement his initiative. In the first place, we have been given to understand the service organizations will both be apprised of progress in the review of the construction validation process and we'll have opportunity to comment. For this, the American Legion is grateful and we pledge our full cooperation.

We will offer our best judgment as objectively as we can, projected, of course, from our obligation to our constituency, the Nation's war veterans.

Our initial appraisal of what is being done here is that the new procedure is essentially an indication of a lack of confidence on the part of the agency management and the quality of work performed in this area by the Department of Medicine and Surgery.

What is happening is that the Administrator is imposing an entire new layer of management supervision under the authority of the Deputy Administrator on top of the work ordinarily assigned to D.M. & S.

One of the elements of congressional oversight of this activity should certainly be to examine into its cost-effectiveness. That, perhaps, can only be determined when the new agency's function has operated for perhaps a year but we do think it is a most important matter for the subcommittee to watch.

We wish to make clear that we reserve the right to challenge any decisions by the new committee that demonstrate a lack of understanding or acceptance of the fundamental mission of the VA system.

As scheduled by the Administrator's new committee, our expectation depending on the criteria used for the reevaluation is that most if not all of them will be found to be justified. We make that statement based on our certain knowledge, on reports from our members, and in the work of our field service that the system is, in fact, a deteriorating system needing massive repair and renovation to enable it to fulfill its fourfold mission.

In this statement and at this time, we are not challenging the right or propriety of the Administrator's initiative to revalidate the medical construction program to the VA.

Cost effectiveness and real need are high on the priority list of all conscientious citizens. We do wonder whether there were not mechanisms already available to him to accomplish this goal. We wonder whether this added layer of management will, in fact, render the operations of the agency more efficient and we have an apprehension the much needed renovation and replacement program could get bogged down in a bureaucratic tangle that could slow the program, thus delaying needed improvements in the system and escalating costs in these times of inflation.

We wish at this time to assure this subcommittee, it is our intention to work as closely with the new committee as we are allowed to do. If problems develop, we hope for permission to bring our concerns to this subcommittee with the confidence it will continue to intensively pursue its oversight function.

We believe the Committee on Veterans' Affairs shares our belief in the importance of the VA health care delivery system and is committed to maintenance of its ability to provide high-quality care to the Nation's sick and disabled.

Thank you.

Mr. EDGAR. Thank you very much for that full statement and your full statement will be made a part of the record.

[The prepared statement of Mr. Lyngh appears on p. 108.]

Mr. EDGAR. Before I introduce Mr. Heilman, as you could hear from the bells ringing there is a vote on the House floor and rather than recess at this point, I'm going to run over and cast that vote and the counsel will recognize Mr. Schwab and Mr. Brinsky and I will be back to ask a couple questions of each of you. This will save you some time and it will also save the committee some time.

I apologize for having to run and cast this vote on whether or not we should adjourn for Easter or not. And I will be back as soon as I can.

Thank you very much. Mr. Heilman.

STATEMENT OF JOHN F. HEILMAN, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. HEILMAN. Thank you. Let me say that we want to commend Chairman Mottl and you, Mr. Edgar and members of the subcommittee for holding these hearings today and for the penetrating questions that you pose to the VA.

We came here today with some reservations and some confusion regarding F-PAC, the facility planning and construction committee. Also, the immediate mission given to it, that of revalidating the 56 projects in fiscal year 1984. And I must say that after hearing the testimony of the VA, we still have these same reservations, perhaps a few more.

For example, again the point was made by the Administrator that he is opposed to mainstreaming and of course, the President is opposed to mainstreaming. And yet, from the document that Mr. Mica introduced we see, in fact, that the Miami facility is mainstreaming veterans. Due to inadequate resources, they are forced

not to extend care to large categories of nonservice connected veterans and veterans with service connected disabilities.

They can't give them prehospital care. They can't give them followup care and in fact, their policy is to refer them to a private physician where they'll get it at their own expense. And if they don't have a private physician, refer them to a social worker, where perhaps they can get it in some other Federal program at more cost to the taxpayer.

We hear the assertion made that it is the chief medical director that is basically in charge of our VA hospital system and planning for its maintenance and expansion.

Yet, at the same time, we hear about evidence indicating that the Inspector General's Office has a very large say as to what is going on in the VA Hospital system; how it's supposed to be expanded. In addition to the example cited by Mr. Daschle, we're aware of the fact that recently an I.G. team visited the Dallas VA medical center unannounced and informed the director there that he was to cease subcontracting negotiations on a 120 bed nursing care unit for which ground was already broken.

It is our understanding that when the director is questioned as to why this decision was being made, why it should be made, the I.G. people referred to, in rather vague fashion, excess beds in the private sector. And when further queried by the director as to what types of beds were out there, were they class 1 or class 2 or whatever, the I.G. personnel professed complete ignorance.

Again, underscoring the point, who is making the decisions regarding expansion of our system and are they qualified to do so?

Quite frankly, we're not opposed as the other organizations have indicated, to any effort aimed at developing defensible guidelines for future expansion of the system.

But we do question the necessity for creating F-Pac, an entity of considerable magnitude when it seems to us there is existing apparatus within VA in terms of the present advance planning process to develop the guidelines, if they are deficient. What about MEDIPP, that's been in existence for 2 years.

We've heard this morning that MEDIPP, who's basically charged with the same type of mission developing strong defensible guidelines, demographic changes, looking at the changes in eligibility, conceptual alternatives, that type of thing. MEDIPP won't be able to come on line until 1985.

And yet, we have F-Pac, just created less than a month ago charged with in a matter of 6 months revalidating 56 hospital projects. We're very confused about that.

I suppose I'll just end by urging the committee to continue this type of oversight function and monitor very closely the actions of F-Pac and certainly the decisions that they'll be making within the next few months regarding fiscal year 1984 construction.

Mr. CASTEEL. Thank you, Rick.

[The prepared statement of Mr. Heilman appears on p. 112.]

Mr. CASTEEL. We'd like to now call on Mr. Donald Schwab, director, Veterans of Foreign Wars for his statement.

Donald, if you could brief yours and we'll accept the full statement in the record.

**STATEMENT OF DONALD H. SCHWAB, DIRECTOR, VETERANS OF
FOREIGN WARS OF THE UNITED STATES**

Mr. SCHWAB. Thank you very much.

As with the others, the VFW is pleased that you're holding this oversight hearing and we hope you have many more along the same line.

We are familiar with the General Accounting Office report on VA construction programs. We certainly believe the VA can cut costs, cost overruns, by doing away with unnecessary modification in plans and construction.

We think the committee should give serious consideration to permitting the VA to go ahead with construction while the House and Senate Veterans' Affairs Committees pass on pending programs.

We're concerned, quite frankly, with mainstreaming as my colleague from the DAV mentioned. I was pleased to hear Mr. Nimmo say this morning that he is opposed to mainstreaming. Unfortunately, he didn't say OMB is opposed to mainstreaming.

You know, last March, OMB came out and recommended mainstreaming of health care. The President alluded to it in the construction deferral last October and Mr. Nimmo alluded to it in his Minneapolis statement. Although Mr. Nimmo said he suffered from foot-in-mouth disease at the time.

Mr. Nimmo has also made some other statements with which we are not comfortable at all. Before this committee, the full committee last month, he characterized wartime service as a mere inconvenience, labeled VA medical care as free medical care, stated further and I quote: "People have an obligation to serve their country and are not necessarily entitled thereby to a permanent social welfare system."

I never considered serving during war a mere inconvenience. I don't think it's free medical care. I believe those with service-connected disabilities have paid mighty dearly for that care and Congress, back in 1924, when it passed legislation which became Public Law 242 in the 68th Congress, placed veterans with non-service-connected disabilities well above social programs.

In that law they granted medical care to any, veteran for any disability resulting from any cause and only gave priority to those who couldn't afford pay.

It seems to me, Mr. Chairman, we hope that this construction moratorium and the FPACC are not vehicles to support the Congressional Budget Office recommendation to close 30 VA hospitals.

We hope it isn't a subterfuge to do that. We know that when the CBO made this proposal, they said that the remaining hospitals and I quote: "Should be more than adequate to handle the needs of all service disabled veterans."

Now, references have been made to care for older veterans, with nonservice-connected disabilities. We have some people in the other body who believe we owe nothing to veterans with non-service-connected disabilities.

These are some of our concerns and again, let me say, we were glad for this oversight hearing and we hope they continue throughout this session of Congress.

[The prepared statement of Mr. Schwab appears on p. 114.]

Mr. CASTEEL. Thank you very much, Don, for your statement. I'd like to follow with Mr. Gabriel Brinsky, the national service and legislative director of AMVETS.

STATEMENT OF GABRIEL P. BRINSKY, AMVETS NATIONAL SERVICE AND LEGISLATIVE DIRECTOR

Mr. BRINSKY. Thank you, Mr. Casteel. My statement will be very short. I'd like to focus only on one point.

We certainly applaud the efforts of the Veterans' Administration to review the effectiveness and to assess its direction.

It was the very question of direction which offered some apprehension, particularly when viewed with response of the Administrator, during the recent press conference, to the effect that the veterans health care system, might be contributing to the oversupply of hospital beds.

Mr. Nimmo, I believe, has satisfactorily explained that statement. There are also comments in his letter dated March 17, addressed to the Honorable Allan Cranston, the ranking minority member of the committee on Veterans' Affairs, which are disturbing. In that letter he stated that the Veterans' Administration was required under OMB circular, A-95 to provide State and areawide clearinghouses an opportunity to coordinate review of proposed VA major construction projects, appropriate health care system, State health planning agencies and other effective agencies in considering such agencies comments.

He continued by stating that the Veterans' Administration appreciated the input of the community health providers and is sensitive to the concerns "we complete or duplicate private sector medical resources."

It appears to us that the Veterans' Administration may be embracing the position of the Office of Management and Budget. Or it would inextricably join the Veterans' Administration planning and construction program with the needs of the private sector.

It is, and always has been, the position of AMVETS that the problems created in the public sector by an overage of beds, currently somewhere in the neighborhood of 130,000 was not the responsibility or obligation of the Veterans' Administration.

The requirements of the Veterans' Administration are different and so our needs. These are well known and I will not belabor the point by enumerating them.

In conclusion, we always are in favor of reassessment or revalidation for improvement or improved management. It is the direction which Mr. Nimmo referred to in his letter to Senator Cranston which causes us some alarm.

This completes my statement. Thank you.

[The prepared statement of Mr. Brinsky appears on p. 118.]

Mr. CASTEEL. Thank you very much, Gabe.

I, on behalf of the chairman, want to thank all of you for appearing here this morning. You know that this full committee and this subcommittee will continue to look very closely at the operations of the Veterans' Administration.

I don't think I have to assure you of that.

It seems Mr. Edgar has returned. However, since there is no further business before the subcommittee we stand adjourned.
[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

APPENDIX

TESTIMONY OF CONGRESSMAN BRUCE F. VENTO

Mr. Chairman and Members of the Subcommittee, it is significant that you have convened this important hearing today on the Veterans Administration Medical Construction Program. Because of the great need for a new facility to replace our present outmoded VA Hospital at Fort Snelling in Minneapolis, the Reagan Administration's plans to radically alter the VA construction program are of great concern to the people of Minnesota. I wish to personally thank Chairman Mottl for his positive response to my letter of March 1 requesting hearings. I am delighted that other Members of the Minnesota delegation share my concerns about the health care needs of Midwest veterans and are taking time to testify with me today.

The need for a replacement VA Hospital in Minneapolis is well documented. Both the VA and the Twin Cities Metropolitan Health Board have studied this project, and both have recognized the inadequacy of the present outmoded facility. Congress authorized and appropriated \$15 million in planning and site preparation funds for this project in fiscal year 1981. We are now asking that this Subcommittee, and the Congress as a whole, proceed as scheduled by authorizing an appropriation of construction funds for the Minneapolis VA Hospital in the fiscal year 1983 budget.

The Reagan Administration and VA Administrator Robert Nimmo are apparently anxious to backtrack on the VA commitment to Upper Midwest veterans. The Administration has not included in its fiscal year 1983 budget request the \$206.4 million in construction funds slated for the Minneapolis VA Hospital. In my opinion, this decision is both irresponsible and economically unsound. The planning process for the hospital replacement project is well underway, and we will be ready to begin construction in fiscal year 1983 as scheduled. If Congress follows the Administration's wishes and delays the authorization and appropriation of needed construction monies, the projected cost of the Minneapolis project will clearly escalate. According to the VA's own figures, each year of construction delay will result in an 11 percent rise in costs. Thus, if we delay just one year, the cost of the Minneapolis VA Hospital replacement project will rise from \$221.4 million to approximately \$245 million. Such a cost rise would very likely result in compromises in the currently planned hospital. I believe we should not accept, and the veterans of the Upper Midwest do not deserve, a second rate or compromise version of the 847 bed facility approved by Congress in 1980.

I am also greatly disturbed by the comments of VA Administrator Nimmo about the Minneapolis project. He was recently quoted as criticizing the Minneapolis VA Hospital on the basis of figures about overbedding in the Twin Cities health care system. While I share Mr. Nimmo's concern about overbedding, I think it is important that he be reminded that his role is not to shape local health care policy. He was appointed VA Administrator to serve as an advocate of veterans needs. Mr. Nimmo knows the need for a replacement hospital in Minneapolis; the VA, his own agency put the project at the top of its priority construction list in 1981. By citing local health care system statistics, all Mr. Nimmo is really trying to do is create a smokescreen behind which he can push construction funds toward more politically important projects. In my opinion, this is not the appropriate way to act as an advocate for veterans. I, for one, would be very interested in learning why Mr. Nimmo has moved the Albuquerque project from fifth to first on the priority construction list. I know the veterans of the Upper Midwest will not benefit from this decision.

Mr. Nimmo has also initiated yet another investigation into the possibility of renovating rather than replacing the Minneapolis VA Hospital. I recently received a report that a team of investigators from the Inspector General's office at the VA Central Office have visited Minneapolis in order to investigate renovation alternatives. Before any new plan for Minneapolis is presented to Congress by the VA, I would like to remind the Subcommittee that renovation was carefully studied before

complete replacement was decided on. Renovation, in fact, was ruled out because the VA found that the cost of renovation to meet future needs equaled almost exactly the cost of building a new facility. I would urge the Subcommittee to be wary of any proposed new renovation plan. Given the progress that has already been made in planning, it would not be economical to cause further delays while investigating renovation ideas which have already been studied and rejected. Any new study should be identified for what it is, a delay tactic and an attempted justification for a new political agenda.

In conclusion, the Minneapolis VA Hospital badly needs replacement. This is widely recognized and well documented. The replacement project, as approved by Congress in 1980, is moving forward smoothly. To continue progress, we now need the construction funds originally scheduled for inclusion in the fiscal year 1983 budget. I strongly urge that this Subcommittee authorize the Minneapolis VA replacement project so that we can proceed with the appropriation of necessary construction funds in the fiscal year 1983 HUD-Independent Agencies Appropriation Bill.

PREPARED STATEMENT OF HON. HENRY B. GONZALEZ, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF TEXAS

Mr. Chairman, I want to thank you for the opportunity to appear here today. I appreciate the great difficulties under which you labor, and so I will be brief.

The Administration budget for fiscal year 1983 includes funding for a 120-bed nursing unit at the Audie Murphy VA Hospital in San Antonio. I am here to urge the Committee to approve this project.

One of the first efforts I undertook as a Congressman was to seek construction of a veterans hospital in San Antonio. At that time, veterans in South Texas had no access to a first-class VA hospital unless they went to Houston or Dallas; the only VA facility was a small unit in Kerrville, many miles distant from the great majority of the South Texas veteran population. There was simply no way that the great bulk of veterans in San Antonio and South Texas could get the VA care that they were entitled to have. I am proud to say that President Kennedy heard my arguments and approved plans for a new VA hospital in San Antonio. This Committee approved the program. I worked closely with the VA, and made certain that the new hospital would be tied in with the vast resources of the new University of Texas Medical School at San Antonio, and that it would be closely associated with the vast medical complex that was then being planned around the medical school. Today, that complex exists and is still growing—and Audie Murphy VA Hospital is part of one of the newest and finest medical centers in the nation. I am proud of that hospital, and grateful to the Committee for enabling its construction. I can tell you that its work has made a vast difference in the lives and hopes of veterans throughout South Texas, and that they and the community are tremendously proud of the hospital.

It was my idea to name the hospital in honor of Audie Murphy—a courageous Texan, and one who despite his fame and courage, had problems not unlike those of many other veterans. He had the personal wealth to provide for his own medical care—but there are many thousands who don't. I thought that this man deserved to be honored, and that nothing would be better than to honor him by giving his name to a facility that provides help and hope to the sick, the injured, and the mentally ill veterans of his home state—care that he could have used, had he not been able to become a financial success.

This is a hospital that has lived up to its promise: it is appreciated, it provides first class care, and it is an immensely valuable medical resource.

Just as the vast number of veterans in my area who need hospital care, there are a vast number who need nursing care. The number who are in need of nursing care is growing, because the veteran population itself is growing older. We need a nursing unit in San Antonio to help meet the needs of veterans who are suffering the effects of age, of ill health, and the consequences of wounds.

The Committee knows, I am sure, that private nursing home operators have opposed this particular project. I want to stress to the Committee, however, that San Antonio does not have a surplus of nursing beds—in fact, it has a substantial shortage. The construction of this project will in no way affect existing private nursing homes—it will only alleviate a small part of the shortage that we have now.

Even if there were no shortage of nursing facilities, it makes sense to have a nursing unit attached to Audie Murphy, so that veterans treated there can have an integrated program of care. For example, young veterans of Viet Nam who need nurs-

ing care could be treated in the same complex where they go for hospital care, under the same medical supervision and under the same program. There would not be any doubt that the VA is responsible for their care—as there now is when they find themselves farmed out to private facilities. In the case of older veterans, I can tell the Committee what a complete heartbreak it is for an older veteran with a condition that cannot be treated, to be sent away from the hospital. There is no way that those veterans, or their families, can accept the refusal of the VA to continue being directly responsible for their care.

These veterans have a point. If the VA is going to be responsible for their hospital care, it makes sense for VA also to provide nursing care when necessary.

There can be no doubt of the need for direct VA nursing care—and there has never been any question that it should be provided, where it is required.

It is clear that a nursing unit is needed in San Antonio, and that the 120 unit facility requested for Audie Murphy is fully justified. This will not meet all the needs we have for VA facilities in San Antonio, but it will meet one of our more urgent needs, and I hope that the Committee will approve this facility. The Chairman knows, I am certain, that I began working to obtain this facility a great many months ago. The VA did not at that time have any definite plans for this project, but when I insisted that they review the facts, they became convinced of the need. Since that time, the Reagan Administration has reviewed this project, and they have also become convinced of the need for it. I know that the Committee, when it reviews this matter, will find that there is the strongest possible case for it.

Mr. Chairman, I will be grateful for your approval of this proposal, and so will the veterans of my city and region.

TESTIMONY OF CONGRESSMAN BILL FRENZEL

Mr. Chairman, I am pleased to have this opportunity to appear before the Subcommittee to discuss the Minneapolis VA replacement hospital. I would like to say at the outset that I am speaking today also on behalf of my two Minnesota Republican colleagues not present today, Representatives Vin Weber and Arlan Stangeland. You will hear from most of the rest of us, and our Senators have the same feelings.

We are all concerned about the Administration's proposed deferment of the Minneapolis hospital. To anyone who has toured the hospital, the deficiencies of the present facility appear serious indeed. Lack of privacy is evident in the 16-bed wards, and medical gasses are not readily available at bedside. Because of dead-end corridors and narrow staircases, some of the buildings do not even comply with fire and safety codes. They have been allowed to remain open only because the modernization plan was in the works.

For these and other reasons, the Minneapolis hospital has headed the VA's list of hospitals in need of replacement or major modernization for three years. The design money of \$15 million was approved in fiscal year 1981, with the other \$265 slated for fiscal year 1983. Nonetheless, the Minneapolis hospital was not included in the Administration's budget request, even though last year's fifth-ranked project, Albuquerque, was.

Every effort has been made to attain a reasonable justification for the delay. On February 18 all twelve Representatives from Minnesota, Wisconsin, and Iowa whose districts are within the Minneapolis hospital's Primary Service Area, as well as the two Minnesota Senators, sent Mr. Nimmo a letter requesting an explanation of this move. We have not yet received an answer, and I am submitting a copy of this letter for the record.

Although I have not heard directly from Mr. Nimmo on this matter, I have nonetheless been confused and disturbed by some of the statements made by Mr. Nimmo and other VA officials in the press and before this Subcommittee. For example, the old argument of the hospital's bed size, which I thought had been settled two years ago, seems to have been resurrected to justify the delay. But since I understand that some of my colleagues intend to address this issue in greater detail, I will not dwell on it.

Instead, I prefer to concentrate on statements made by VA officials before the Veterans' Affairs Committee on March 1. When asked by Representative Mottl why the Minneapolis hospital had been delayed while Albuquerque was fully funded, they gave some rather curious responses, principally dealing with the VA's actual list of priorities and with the delay in the planning for the hospital.

First, Mr. Nimmo submitted that Minneapolis was pulled off the list of ten by action of Congress. This is an unfortunately inaccurate statement, but Dr. Custis compounded the confusion further by stating that "it was not intended that they

were listed in one, two, three priority order." He also mentioned that there may have been included in that list some projects that the VA knew would not be ready for budget insertion before 1984 or 1985.

I do not believe it is necessary to comment on Mr. Nimmo's statement, except to say that it is wrong. However, in reference to Dr. Custis' remark about priority order, I would like to call attention to Section 5007 of Title 38, which mandates the submission of the five-year construction plans by the VA. Part of this section calls for "a list, in order of priority, of not less than ten hospitals that, in the judgment of the Administrator, are most in need of construction or replacement." Finally, although most of the projects on last year's list were indeed scheduled for construction in fiscal years 1984-1986, the fact remains that the Minneapolis hospital was slated for construction money in fiscal year 1983.

Another alibi was provided by Mr. Sullivan when he stated that the reason Minneapolis was not included in the 1983 budget was that the design phase for the Minneapolis hospital had not yet been completed. This is true, even though Minneapolis received its design money in fiscal year 1981, a full year ahead of Albuquerque. Not surprisingly, Mr. Sullivan neglected to point out that we are in our present position largely because of a nine-month delay by the VA in awarding the design contract. Poor administration in Washington was the sole cause of that delay.

Moreover, I feel it is a little misleading to imply that Minneapolis will not be ready for construction money in fiscal year 1983, and that hence there is no reason to put it in the budget. It is my understanding that the working drawings are scheduled to be completed in June of 1983, before the end of the fiscal year. Also, I have been told that the VA can award a construction contract even before all the working drawings are completed.

There have been additional delays in other hospital work, work for which money was appropriated in fiscal year 1981. In order to proceed with the project, a temporary clinic building must be constructed and some of the older buildings have to be demolished. The invitation for bid on this work, I believe, had been scheduled for January of this year. The VA has put a hold on these plans, however, and further delays could mean that the date at which which construction could commence might be pushed past the beginning of fiscal year 1984.

On February 19 Mr. Nimmo announced a major reexamination of the VA's medical facility construction program. Apparently, it was determined that Albuquerque did not require such a reexamination while Minneapolis, which had been first on the VA's list for three years, did. Mr. Nimmo stressed that all projects must meet "new and definite criteria" before being restored to the construction schedule. Unfortunately, though, new criteria will not correct the serious problems the present Minneapolis facility faces. And unless the VA intends to close down medical services, it must keep a hospital in Minneapolis for an extended period of time.

Keeping this in mind, the only alternative to a replacement hospital is to continue patching up the present structure with more renovations and repairs. This option, I feel, is neither practical nor economical. In fact, in 1979 the VA Office of Construction Estimating Service reported that a replacement hospital would cost less than \$1 million more than a plan involving considerable renovation of some of the old buildings. An Inspector General audit team was in Minneapolis in February to review the construction plans, and I expect to hear that still another "re-evaluation team" will be sent out later this year.

Although I do not believe the Inspector General's report has been released, I understand that plans involving considerable renovation of some of the old buildings are being seriously considered. I hope I am mistaken, since I feel that this would be a serious mistake. Switching gears to an extensive renovation program at this point would not only mean further delays, but we would also end up with essentially an old hospital, albeit with a multi-million dollar face-lift. If the VA is, however, still committed to a new hospital in Minneapolis, I hope the nagging delays we have experienced will soon cease.

I thank the Subcommittee for giving me this chance to testify. The veterans served by the Minneapolis hospital hope that Mr. Nimmo will address some of these concerns in his testimony.

CONGRESS OF THE UNITED STATES,
Washington, D.C., February 18, 1982.

Mr. ROBERT NIMMO,
Administrator, Veterans' Administration,
Washington, D.C.

DEAR MR. NIMMO: We are all concerned about the fate of the Minneapolis VA hospital, which serves the veterans we represent.

Although the Minneapolis VA hospital provides good care to the veterans of our region, its staff has been increasingly hampered by serious space and functional problems. Recognizing these deficiencies, the VA, in its Five Year Plan of June of 1981, placed it first on the list of hospitals in need of replacement or major modernization. The design funding of \$15 million was appropriated in fiscal year 1981, with the other \$265 million slated for fiscal year 1983.

Nonetheless, the Minneapolis hospital was not included in the Administration's budget request. We recognize the need to control federal pinch. However, the plans for this modernization have been in the works for years, and we do not feel that an adequate justification has been made for delaying it. The need for a new hospital remains, and will increase in the years to come as more and more World War II and Korean War veterans reach retirement age.

What also worries us is that the Minneapolis hospital seems to be slipping on the VA's list of priorities. One obvious example is the inclusion of \$103.5 million in the budget for the Albuquerque hospital, which had been fifth on the VA's list. Albuquerque is a less expensive project, but it also has fewer beds and serves a much smaller service area. We have also heard disturbing reports that other projects, such as the Houston facility, may be moved above Minneapolis.

Budget cuts have become a fact of life, but they must be made on a fair and even-handed basis. We have not come this far to see the Minneapolis hospital forgotten as other, lower priority, projects are fully funded. The planning for Minneapolis is underway, but certain site preparation activities (funded by the \$15 million already appropriated) have been halted. This delay, along with the funding of the Albuquerque hospital, make us question the VA's commitment to the modernization of the Minneapolis facility.

We would appreciate hearing from you concerning the justification of this apparent reordering of priorities, as well as the plans you have for funding the Minneapolis hospital.

Yours very truly,

Bill Frenzel, Arlen Erdahl, Tom Hagedorn, James Oberstar, Cooper Evans, Steve Gunderson, Arlan Stangeland, Bruce Vento, Vin Weber, Martin Sabo, David Obey, Berkley Bedell, Members of Congress; Rudy Boschwitz, David Durenberger, Senators.

STATEMENT OF CONGRESSMAN MARTIN O. SABO

Mr. Chairman and members of the committee, as you all know, the Minneapolis Veterans Administration Medical Center has been number one on the construction priority list of the V.A. for several years. After extensive review by both the local V.A. administrator and the Congress, this committee authorized and the Appropriations Committee appropriated planning funds for this hospital. These funds were appropriated in 1981 with the clear understanding that construction would begin in 1983.

The Reagan Administration has seen fit, however, to delete funding for this project from the 1983 budget. Upon questioning in the HUD subcommittee appropriations, Mr. Nimmo informed me that he feels a need to revalidate this project, along with most other V.A. construction projects.

Mr. Chairman, this project has been studied and validated to death. This hospital is old and outmoded. No one has quarrelled with the fact that something needs to be done with it. Even Mr. Nimmo concedes that.

The Ellerbe firm, a nationally prominent architectural firm which specializes in hospital design, made extensive studies of the Minneapolis hospital. Based on their work, both the local V.A. administration in Minneapolis and the central V.A. administration in Washington concluded that replacement of the hospital was more cost-effective than renovation.

Mr. Daniel Cooney, the Minneapolis hospital administrator, and his staff inform me that this V.A. hospital has been designed from the local level up. The administrator and his staff have spent untold hours working with the architects on the plans for the new hospital. They have a very good relationship with the architects

and they tell me the plans are moving along on schedule. V.A. officials have also testified before the HUD subcommittee of Appropriations that they would be able to begin construction of the Minneapolis hospital if funds were available in 1983.

As you know, the construction season in Minnesota is very short. Sometimes a one month delay can set a project back a whole year.

Mr. Chairman, as you know, the 1983 budget is currently in a state of great disarray. I do not know if it will be possible to find the funds necessary to begin construction of this hospital or not. I urge you to authorize the hospital, so that if we can find the funds, the appropriation can be made and this project can move ahead as planned.

STATEMENT OF HON. TOM HAGEDORN

Mr. Chairman and Members of the Subcommittee, I'd like to thank you for this opportunity to testify today on behalf of a project of vital importance not only to the veterans of Minnesota and surrounding states, but to all the nation's veterans who are or will be in need of medical care. In particular, I'd like to express my appreciation to you, Mr. Chairman, for your help in keeping interested Members informed of developments with regard to the Minneapolis project.

While I am pleased to speak on behalf of the planned replacement hospital for veterans in Minneapolis once again, I am somewhat concerned that my colleagues in the delegation and I must come today prepared not only to support the new hospital but to defend its viability. I am dismayed that the need for this new facility is being questioned from within the Veterans Administration itself.

The proposed fiscal year 1983 V.A. budget does not include funding for a replacement hospital in Minneapolis, but does contain \$103.5 million for the Albuquerque replacement project. In its 1981 Five Year Medical Facility Construction Plan, the V.A. had placed the Minneapolis facility first on its list of hospitals in need of replacement or major modernization. The Albuquerque hospital was fifth on the list at that time.

My concern deepened when I read certain comments of Administrator Robert P. Nimmo published in a Texas newspaper, which Chairman Mottl kindly brought to my attention. In this article, Mr. Nimmo questions the sense of replacing the present V.A. hospital in Minneapolis when he contends that there are 2000 empty beds in private hospitals in that city.

The entire Minnesota delegation and several other concerned Members cosigned a letter to Mr. Nimmo requesting an explanation of the V.A.'s plans for funding the Minneapolis hospital. I wrote a second letter to the Administrator regarding the newspaper article, but we have not yet heard from him on this matter. If he can indeed support these reckless accusations, then I would respectfully suggest that he answer our letters.

We are all very much aware of the need to reduce federal spending. I have been a strong supporter of the efforts to eliminate unnecessary spending and realize that no area, including the Veterans Administration's budget, is exempt from these reductions. If there are any questions about whether or not I advocate unnecessary spending for political reasons, I invite skeptics to look at my voting record.

However, I must be wary of any moves which would seek to weaken the nation's commitment to providing quality care and services to the men and women who have served and defended this country in times of national need. Quality medical care is perhaps the most important benefit we can provide our veterans, and it is one that will become more meaningful as the veteran population ages.

The need for a replacement hospital in Minneapolis is unquestioned. The original buildings of the medical center were erected in 1927, with additional major construction in 1953. In its April 3, 1980 report on the proposal to build a replacement hospital in Minneapolis, the Veterans Administration's Department of Medicine and Surgery reported that critical space and functional deficiencies existed within these aging buildings. In fact, the Minneapolis facility was ranked among "the three most deficient in the V.A. system" in 1980. No significant improvements have been made since that time.

Extensive study and evaluation preceded the decision to provide funding for this new hospital, and I know of no new information which would invalidate the conclusions of the Department of Medicine and Surgery two years ago. I quote from the same report: "The demographic studies, the bed-sizing studies, and the tools of the planning process . . . clearly support the need for this project."

In light of the strong evidence demonstrating the need for a new hospital, I find it difficult to imagine any so-called newly developed criteria which, when applied to

this plan, would call into question its viability. I certainly do not object to the Veterans Administration strengthening its checks on wasteful spending. I do object, however, to this project being called into question when it has already passed thorough checks, reviews and evaluations approved by the Office of Management and Budget, the House and Senate Veterans Committees, the Veterans Administration itself and the full House of Representatives.

Trying to achieve reasonable savings is one thing; manipulating criteria in an effort to achieve false savings is quite another point. Additional delay of this project on the pretext of reevaluation is unwarranted, unnecessary and counterproductive. The project will become more expensive the longer we wait to begin construction. I would also suggest that such delay is less than what the more than 800,000 veterans in Minnesota, North and South Dakota, western Wisconsin, and northern Iowa who are served by this regional tertiary care hospital deserve.

Two years ago, the number of beds this new facility should have was an issue of some controversy in the House. At that time, the local Metropolitan health board recommended that the size of the facility be restricted to 649 beds rather than the 845 bed level approved by the V.A. and supported by the Congressional Veterans Committees, O.M.B., and all veterans groups. The reason for the proposed reduction was an alleged surplus of hospital beds in the metropolitan area.

The House Appropriations Committee attempted to implement this restriction through language in the H.U.D.-Independent Agencies fiscal year 1981 appropriations bill. Fortunately, an amendment I offered to stop this effort and restore funding for the 845 bed facility was successful. The House clearly expressed its approval of these plans by an overwhelming vote on the floor.

Several points were made at that time regarding local bed surpluses and the mission of Veterans Administration hospitals which I believe are quite relevant in view of some of Mr. Nimmo's comments. As I said before, the Minneapolis hospital is a regional facility serving veterans in a five state area and beyond, and is part of a national system which provides care to the nation's 30 million veterans. A much-needed facility like the Minneapolis V.A. Medical Center cannot be compromised in an effort to remedy the local problem of overconstruction of hospital beds. The V.A.'s mission is to serve veterans, not solve the shortsighted problems of local health planners.

Furthermore, empty beds in private hospitals do not fulfill the needs of veterans for medical care. The mission of the V.A. medical care system is unlike that of private hospitals, whose interest in the patient is limited to the particular medical problem at hand and ceases at discharge. The V.A., on the other hand, provides a continuum of care to veterans, which extends to their general physical and economic well-being and does not simply end at discharge. It goes far beyond a two week occupancy of a hospital bed. To suggest that any bed in any hospital is good enough for a veteran injured in service to the nation is, I believe, a great disservice to these men and women.

I might also mention that proposals for a voucher system of providing medical care to veterans have never been supported by evidence that this would be less expensive to the federal government.

In conclusion, I want to reiterate my strongest support for the earliest possible funding for construction of a new Minneapolis V.A. hospital. The need for this facility has been proven beyond all doubt and I have seen no evidence to justify further delay.

The veterans who rely or will rely on the Minneapolis hospital for medical care deserve better than the feet-dragging and the repeated episodes of uncertainty and ambiguity that they have had to endure thus far.

I congratulate this subcommittee for keeping a responsive and responsible watch over the V.A. medical care system and I am confident you will see that the medical needs of veterans continue to be met.

STATEMENT BY CONGRESSMAN ARLEN ERDAHL

Mr. Chairman and Members of the Subcommittee, I am most grateful for the opportunity to address this distinguished Subcommittee on a matter of vital importance to many many veterans in the upper Midwest.

It seems unfortunate that the Congress should have to address itself once again to the matter of VA hospital construction in Minneapolis when just two short years ago Congress decided that a new VA hospital in the Twin Cities was needed to serve the veterans from the Midwest. As you stated in an earlier letter to me, Mr. Chairman, the Congress heard and soundly defeated arguments which claimed that the

current number of empty beds in the Twin Cities area hospitals will meet the needs of the veterans in the coming decades. Testimony was heard from different witnesses which pointed out that there is currently a surplus of 2000 beds in the metropolitan area. Efforts were made in the Appropriations Committee and on the floor of the House to limit the number of new beds that would be included in the new hospital. Yet with all this, an overwhelming majority of the House agreed that the Medical Center should be built with 845 beds.

Why did the Congress refuse to heed the predictions of those who foresaw hundreds of unused hospital beds in the Twin Cities?

Primarily for two reasons. First, because the current facilities are woefully inadequate. The Minneapolis VA hospital was rated one of the three worst facilities in a 1977 space evaluation study survey of all 172 VA hospitals around the country.

Let me take just a moment to describe some of the handicaps which patients and hospital personnel must endure at the current facility. First, the hospital does not comply with fire and safety codes. Many of the hospital's hallways are dead end corridors leaving evacuation during an emergency extremely difficult. In fact, the hospital would be closed were it not for the planned new construction. Unnecessary delays on the part of the Veterans Administration can only exacerbate this situation.

Other difficulties with the current facility include the lack of privacy for patients and families. Currently many wards are made up of sixteen beds. There are no adequate toilet facilities for the patients, and there are no waiting rooms or conference rooms for surgeons and doctors to meet with patients' families. Further, the existing facility is really a group of several buildings. Patients are now required to travel long distances between buildings to receive their treatment. Modernizing the present buildings by installing elevators to relieve the dead end corridors would not eliminate the travel distances, but would be very expensive.

Further, medical gasses are not immediately available at a patient's bedside. Portable tanks must be wheeled in and out as the need presents itself.

I could go on and on in this fashion but I think my point has been made. Our veterans should not be expected to settle for second-rate facilities. At this point it would be a mistake to imply that the care and the attention given veterans at the Minneapolis hospital is in any way second-rate or less than professional. The VA's track record in this area has been very impressive. However, as medical science continues to press forward with new developments, the physical condition of the hospital can and will have a direct impact on the quality of care a patient receives. There is no reason why we cannot act decisively at this point to avert some of these present and future dilemmas.

The second reason why Congress agreed to new hospital construction in Minneapolis was the demographic studies which predict an increased demand for hospital beds among veterans in the coming decades. According to official reports from the VA, the veteran population in Minnesota is increasing, not declining. The VA Official Report dated September 1978, states that there are 556,000 veterans in Minnesota. The VA Official Report, dated September 1981, states that there are 560,000 veterans in Minnesota. This is an increase of 4,000 veterans in the State in three years. Further, the number of older veterans in Minnesota, Northern Iowa and Western Wisconsin is expected to more than double from 47,000 to 110,000, by the year 1990. These figures are not even taking into account that the Minneapolis medical center serves a seven state constituency of Minnesota, North Dakota, South Dakota, Iowa, Wisconsin, Nebraska, and Wyoming. The testimony which was heard on previous occasions concerning the Minneapolis hospital often made mention of 2000 empty beds in the Twin Cities area. These beds, however, are in the private sector, and unless the VA is advocating mainstreaming our veterans into the private sector, these beds should have little or no effect on the VA Medical System.

Some may contend an increase in the number of veterans is no proof of an increased demand for hospital beds. The Minnesota Department of Veterans' Affairs, however, has recently completed a statewide survey entitled, "Veterans' Longterm Health Care Study." In one part of this study the researchers polled the seven health system areas in Minnesota to determine what the demand will be for hospital beds in the coming years. Let me quote directly from this report at the point at which it addresses the ratio of supply to demand for hospital beds:

"... the supply (of beds) exceeds the low demand/preference estimate for 1980. The 1990 low estimate assumes the Veterans Administration 200 bed Board and Care Facility at St. Cloud as well as the 120 bed nursing facility at Minneapolis will be available. If these two facilities are not built, the figures for 1990 and 2000 must be increased by 320 beds. If Minnesota's elderly veterans are to receive the same service in 1990 and 2000 as were available in 1980, the number of MDVA (Minneso-

ta Department of Veterans Administration) beds will need to be increased by the 754 beds by 1990 and 978 beds by 2000. This would satisfy the low preference. To satisfy the high preference would require more than 3,800 additional beds."

Mr. Chairman, the evidence is overwhelming that the new Minneapolis VA hospital is needed now to serve the health needs of veterans from the upper Midwest. Furthermore, the evidence shows that the need for this new facility will increase in the coming years. We as a people and as a government are obligated to meet the health needs of our sons and daughters who served in the defense of our country. We have asked them to sacrifice much, to preserve peace and freedom in our land. The time has definitely come when we will have to sacrifice for our veterans.

Let me conclude by paraphrasing a famous quote from Simone de Beauvoir's, "The Coming of Age." " * * * by the way in which a society behaves toward its old people (and veterans) it uncovers the naked, and often carefully hidden, truth about its real principles and aims." Let's not be a society guilty of neglecting its elderly or its veterans.

TESTIMONY OF ROBERT P. NIMMO, ADMINISTRATOR OF VETERANS AFFAIRS

Mr. Chairman and members of the subcommittee, I am pleased to appear before you to testify in support of the Veterans Administration's fiscal year 1983 construction authorizations request and medical construction program.

For fiscal year 1983, the major medical construction program includes 21 projects requiring Veterans' Affairs Committee authorization. The request for major medical facility construction projects totals \$449,922,000 for fiscal year 1983; of that amount \$292,326,000 requires Committee authorization.

Projects included in the request continue an emphasis on construction of facilities required to meet the needs of an aging veteran population. To meet these projected needs, authorization of four new nursing home care units and two projects to make outpatient improvements is requested.

A renewed emphasis on the identification and correction of life/safety code deficiencies in existing facilities is also reflected in the request. Specifically, the request includes projects to make fire/safety improvements at five stations and electrical improvements at three others. Further, major replacement/modernization projects proposed for Albuquerque, Biloxi, and San Francisco, as well as various other projects in the request, include life/safety improvements in existing buildings or replacement of buildings which cannot be economically upgraded. Other projects requiring authorization involve clinical improvements, ward modernizations and other patient facility improvements.

I will be pleased to discuss the details of our construction authorization request and construction program with you and Members of the Subcommittee. Before doing so, however, I would like to take just a few more moments to comment on my decision, announced on February 19, to comprehensively review the VA's medical facility construction program for fiscal year 1984 and the outyears.

My decision to assess the Agency's fiscal year 1984 and outyear Major Construction projects was prompted by the need to ensure, prior to actual construction funding, that those projects are fully responsive to veteran health care needs; appropriately sized, scoped and located; and based on valid workload data and accurate space and functional criteria.

The objective of our review is not to delay vitally needed medical facilities for our veterans or cutback on the VA's medical facilities construction budget. Rather, the objective is to make sure that the dollars we spend are spent wisely and on the best projects possible. Revalidating the need for and scope of each project we are considering for construction is the most direct means of reaching that objective. I believe it is important that we assure ourselves, the veterans we serve, and Congress that the projects we present for construction funding, some placed in the pipeline five or six years ago, are still needed and justified.

Recent Congressional concerns have highlighted the need for improvements in the VA's planning, project prioritization, and construction processes. Recent General Accounting Office reports have identified perceived problems in the VA's planning and construction programs. Recent audits by the VA's Inspector General have found some instances of lack of workloads to justify planned construction; questioned excessive building costs in such areas as VA nursing home care units; and also indicated problems in the Agency's planning and construction programs.

We have to be responsive to these concerns and improve our facility planning and construction procedures to minimize the problems identified.

These are the goals of the construction program review, and we are approaching our task at several different levels.

First, Agency personnel are preparing a report for me which will update the last major overview of veteran health care needs and the options to meet those needs which were done in 1977-1978. Based on this report and discussions with VA's top management, I will issue updated policy guidance which will provide direction to our long-range planning for the VA's health care delivery system.

Second, the Department of Medicine and Surgery is reviewing the VA's domiciliary and nursing home care programs and will provide recommendations to me on the future construction needs of those programs.

Third, on February 1, I established a top-level VA Facility Planning and Construction Committee to review policy options and analyze and recommend refinements and improvements in our planning and construction procedures. Some members of this Committee also will serve as the steering committee for our revalidation of future construction projects.

Given our deep concern over the Agency's inordinate nursing home construction costs, I established a separate task force to explore appropriate methods of effecting cost reductions. The task force has just finalized its first set of recommendations. These recommendations were approved by all affected elements in the VA and will reflect a total cost reduction for a 120-bed VA nursing home in the order of magnitude of \$800,000 to \$1 million. We are optimistic that further cost savings can be achieved.

With respect to the revalidation process, we will begin with revalidation of that pool of projects potentially eligible for construction funding consideration in fiscal year 1984. Projects viewed as potentially eligible are those which, at this time, appear possible candidates to have their preliminary plans and cost targets completed by October 1982. A list of these potential fiscal year 1984 projects was developed by the Department of Medicine and Surgery and the Office of Construction and consists of a total of 56 Major Construction projects with a combined estimated cost of over \$1.2 billion. Of these 56 projects, only those projects which justifiably entail direct patient safety such as electrical deficiency corrections, fire and safety improvements, and/or seismic strengthening are excluded from the fiscal year 1984 revalidation process.

The project revalidation list has been divided into six groups, by Medical Region, and each group assigned for comprehensive review to one of six revalidation teams. The teams are composed of a representative from the Department of Medicine and Surgery, the Office of Construction, and the Office of Budget and Finance. The revalidation review will entail both Central Office review as well as onsite visits, where necessary, to revalidate the project's need, justification, workload data, and scope. The revalidation review for all potential fiscal year 1984 projects is to be completed in time for final review and decision on the Agency's fiscal year 1984 construction budget request.

I wish to emphasize that no health care project either funded or already under construction is affected by the revalidation review. Revalidating such projects could have resulted in delay of needed medical care facilities, subsequent increased costs, and in some instances, possible contractual liabilities. In addition, no fiscal year 1983 project for which the VA has requested construction funding is included in the revalidation as the revalidation process would have been unduly disruptive of both the VA's and Congressional budgetary process. The logical year for us to begin revalidation was with potential fiscal year 1984 construction projects. Focusing on these projects, still in an early stage of design, will mitigate potential project delays and avoid costly design changes if such changes are found to be needed.

Further, for those projects which are being revalidated, design work will be continued on schedule, unless significant problems are identified by the revalidation process which would require that the project be rescope.

Regrettably, a few have misconstrued this construction review as a possible step to "mainstreaming" or the dismantlement of the VA health care system. I am just as opposed to that idea as when I was confirmed as Administrator of Veterans' Affairs. I made that clear to the Senate at my confirmation hearing last year, and I repeat it here. I believe that those who call for "mainstreaming" the VA medical health care system possess little understanding of that system. Indeed, the term itself is a misnomer. The VA health care delivery program is already "in the mainstream" of American medicine and will continue to remain a leader in this Nation in providing quality health care, medical manpower training and vitally needed research.

As you know, of course, the Veterans Administration is required under OMB Circular A-95 to provide State and areawide clearinghouses with an opportunity to co-

ordinate review of proposed VA Major Construction projects with appropriate Health Systems Agencies, State Health Planning Agencies, and other affected agencies and consider such agencies' comments. While this Agency's statutory mission is and remains the provision of quality comprehensive medical and hospital service to eligible veterans in VA facilities, I believe it is imperative that we are able to fully justify the bed-sizing and medical services we select for our hospital and nursing home care projects. My recent reference, for instance, to the 2,000 empty non-VA hospital beds in the Minneapolis area reiterated the concerns of the Minneapolis Metropolitan Board of Health regarding the size of the VA's Minneapolis replacement project. In the case of Minneapolis, the project has not been funded for construction and will be included in the revalidation process. Minneapolis is one of our finest affiliations and we know that a major improvement of that facility is essential. Our revalidation of the Minneapolis project is simply to insure that our construction plan is consistent with the needs of the veteran population in that area. I want to emphasize, again, that the VA is not proposing any change in the extent to which non-VA resources are or will be used in the medical treatment of eligible veterans. The construction review also is not a step toward undermining important medical school affiliations and medical education and research which are critical to the VA's provision of quality health care. I believe that we need to continue to plan facility construction which will result in providing high-quality health care in the most cost-effective manner. But construction dollars assigned to medical school affiliations must compete for the Agency's resources just as would any other program.

In closing, there are several points I wish to emphasize. First, I want to strongly emphasize that the construction program review is not an attempt to delay or discontinue the VA's vital medical facility construction program. I wish to make that clear for the record. The purpose is simple and straightforward: to make sure the projects we submit to Congress for funding are fully justified and responsive to veteran health care needs.

Second, the construction program review is not a repudiation of the VA's health care planning effort. Rather, it reflects the dynamic aspect of the planning process and the need to constantly update and refine our planning and construction programs. The basic considerations which drive the Agency's construction program have not been comprehensively reassessed since 1978. Since that time, eligibility for VA health care has changed; the demographics of the veteran population have altered; and more accurate and sophisticated models and data bases exist on which to project the Agency's long-range planning.

Further, significant deficiencies have been identified in the VA's current construction planning process. The Agency has recognized these and, in response, the Chief Medical Director initiated development of the Medical District Initiated Program Planning process, or MEDIPP. MEDIPP, however, is not fully developed and the first construction year in which it will impact is fiscal year 1985 or later. In the interim, we must take further initiatives, update the policies which will guide MEDIPP, and ensure that those projects planned without the benefit of MEDIPP can pass the test of revalidation. Given the current environment of budgetary constraint, the need to be able to objectively prioritize and justify our construction projects, reduce our actual building costs, and improve our planning process has never been greater. I am pleased that the chief Medical Director, Dr. Donald Custis, has given his full and unqualified support to this planning initiative.

Finally, my goal as Administrator of Veterans Affairs is to ensure the continued provision of a quality integrated and comprehensive health care system to meet the needs of our veteran population. To fulfill that goal, we must also ensure that the VA has the best medical facilities construction program possible, guided by a coherent, consistent and comprehensive planning process, responsive to veteran health care needs, and based on defensible, objective and accurate criteria.

The construction review I have initiated is dedicated to serving and ensuring that end.

This concludes my prepared statement.

VETERANS' ADMINISTRATION,
Washington, D.C., April 21, 1982.

Hon. RONALD M. MOTT,
Chairman, Subcommittee on Hospital and Health Care,
Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to respond to Congressman Edgar's request at the Subcommittee hearing of April 14, on the Veterans Administration's Medical Facilities Construction Program, regarding the curtailment of outpatient services at

the Miami Veterans Administration Medical Center for certain veterans, as articulated in a notice from the Director of the Medical Center entitled "A Message to Veterans Receiving Care for Non-Service Connected Conditions."

As you are aware, the law provides that the VA has authority to restrict the provision of outpatient medical services to eligible veterans according to a specific order of priority. First in priority are veterans for a service-connected disability, followed next by veterans with a service-connected disability rated at 50 percent or more. Our commitment to these groups of beneficiaries must be fulfilled before consideration can be appropriately extended to others. Veterans with service-connected disabilities rated less than 50 percent who require treatment for nonservice-connected disabilities follow these previously-mentioned groups in the order of priority. Former prisoners of war and certain Vietnam-era veterans are to be accorded the next order of priority. Finally, World War I veterans and certain pensioners have priority for services for their nonservice-connected disabilities. (38 U.S.C. § 612(i)). These veterans are to be accorded priority over all other eligible veterans who are not included in the statutory priority scheme. Accordingly, heavy demand placed on the resources of VA facilities may demand the development of policies at those facilities which assure the provision of VA medical services to veterans who are accorded a statutory priority.

It is my understanding that the notice about which you inquired was distributed to veterans at the Miami facility in May 1981 and stated that because services at the hospital were being taxed beyond the facility's resources, it would be necessary to curtail outpatient services for certain veterans, including the nonservice-connected disabilities of service-connected veterans rated at less than 50 percent disabled. However, this policy was rescinded soon thereafter. When this policy was rescinded, no additional copies of this notice were distributed and as many as possible were retrieved. Unfortunately, it is our understanding that a copy of the notice was recently posted again on a bulletin board in the hospital. It is my opinion that the medical center's proposed curtailment of outpatient services to service-connected veterans in this situation was not consistent with the statutory priority scheme since the medical center would at the same time have been providing these services to veterans with a lower priority.

In further review of the admissions policy as stated in the "Message to Veterans," officials at the Miami Medical Center have amended their prior position on the duration of outpatient post-hospital treatment afforded nonservice-connected veterans. The treatment provided to veterans with nonservice-connected disabilities who are still receiving post-hospital treatment to complete an acute episode of VA inpatient care will be reviewed after six instead of three months. Each review will determine whether the veteran's condition requires additional follow-up visits to arrest or stabilize the condition. Whenever feasible, the veteran will be encouraged to seek continued treatment from his or her family physician at the veteran's own expense. In instances where the veteran does not have access to the required treatment in the community, the Center will provide treatment as necessary, until appropriate alternative arrangements can be made. I believe this is a responsible step, consistent with provisions of title 38, which state that such services will be provided within the limits of VA facilities.

I regret that a copy of this notice was posted at the Miami hospital, but I wish to assure you that all service-connected veterans, regardless of their disability rating, will be receiving outpatient services for nonservice-connected disabilities at the facility.

Sincerely yours,

JOHN P. MURPHY, *General Counsel.*

APRIL 1, 1982.

HON. BILL FRENZEL,
House of Representatives,
Washington, D.C.

DEAR MR. FRENZEL: Your interest in the Veterans Administration Medical Center in Minneapolis, Minnesota, as expressed in your letter of February 18, 1982, is appreciated.

The design work for the Minneapolis project is still in an early stage and a cost target was not available on which to base a construction funding request in the FY 1983 VA budget submission. In contrast, the preliminary plans for a new Clinical Services and Bed Building at Albuquerque, New Mexico, were completed in April 1981, and a cost target in the amount of \$115 million was approved on June 19,

1981. Based on the completion of the preliminary plans and cost target for the Albuquerque project, this project was included in the VA's FY 1983 budget request.

On February 19, I announced that all major construction projects potentially eligible for construction funding in fiscal year 1984 or the outyears would be reviewed and revalidated. The revalidation will include an assessment of each project's need, workload projections, veterans' demographics, staffing, and space requirements to ensure that the project is still fully justified and responsive to veteran health care needs.

As the Minneapolis project has not been funded for construction, it will be one of the projects included in the Agency's revalidation process. This review, together with any recommended changes in project scope which might result, will be assessed by the Chief Medical Director and me. The design of the Minneapolis replacement project will not be delayed during the revalidation review unless agreement is reached that the review findings are of such significance that further design work should be halted in order to rescope the project. The revalidation process will ensure, prior to the commitment of several hundred million dollars, that the projects we recommend to Congress represent the best allocation of construction dollars possible and are the most effective response to the health care needs of veterans.

I will keep you informed of the results of the revalidation review of the Minneapolis Replacement Center. Thank you for expressing your concern.

A similar response has been sent to the other signatories of your letter.

Sincerely,

ROBERT P. NIMMO,
Administrator.

FISCAL YEAR 1984 MAJOR REVALIDATION PROJECTS BY MEDICAL REGION, REVISED AS
OF APRIL 6, 1982

Attached is the list of projects being revalidated by one of the VA's six Revalidation Teams for possible fiscal year 1984 budget consideration. The original list of projects potentially eligible for fiscal year 1984 budget consideration totaled 56. The attached list totals 54 projects which reflects the deletion of three projects which the Chief Medical Director agreed would not be ready for fiscal year 1984 budget consideration and the addition of one project which potentially will be ready. The revalidation review on all of these 54 projects is essentially proceeding simultaneously in order that each project review will be completed in time for consideration in the VA's fiscal year 1984 budget preparations.

DELETIONS

Newington, Conn., Project No. 627-032, Addition to Buildings 1 and 2.
Beckley, W. Va., Project No. 517-013, Clinical Addition and Alterations.
Hot Springs, S. Dak., Project No. 579-040, Clinical Addition.

ADDITION

San Diego, Calif., Project No. 664-028, Emergency Generator and Conservation of Energy.

**PROJECTS FOR REVALIDATION—MAJOR FISCAL YEAR 1984 REVISED AS OF APR. 6, 1982, BY
MEDICAL REGION**

(Dollars in thousands)

Medical center	Project identification	Project title	P.P. Comp.	Cost
Medical region 1—Northeastern				
Bath, N.Y.....	514-068	Renovate building 78 for NHC.....	December 1980.....	\$7,200
Brockton, Mass.....	525-016a	Modernize buildings 2 and 7.....	October 1979.....	29,500
Brockton, Mass.....	525-021	Addition and renovation for SCI.....	June 1982.....	6,800
Buffalo, N.Y. ¹	528-039	Res. and education facility.....	March 1981.....	27,400
Castle Point, N.Y.....	533-056	Building addition.....	May 1981.....	15,000
Manchester, N.H.....	608-014	Laundry, warehouse, engineering facility.....	October 1982.....	10,000
New York, N.Y. ²	630-025	Upgrade electrical distribution, phase II.....	October 1982.....	4,000
Northport, N.Y.....	632-062	120-bed NHCU.....	September 1982.....	13,800
Providence, R.I.....	650-025	60-bed NHC.....	October 1982.....	6,500
Syracuse, N.Y. ²	670-016	F/S improvement, patient privacy and support system.....	May 1981.....	12,000
10 projects, total.....				<u>132,200</u>
Medical region 2—Mid-Atlantic				
Clarksburg, W. Va....	540-008	Clinical addition and alterations.....	December 1982.....	15,000
Durham, N.C.....	558-025	Additional elevators.....	December 1981.....	4,300
East Orange, N.J.....	561-034	Reloc./consul. res.....	October 1982.....	5,300
East Orange, N.J.....	561-035	120-bed NHCU.....	February 1983.....	15,000
Fayetteville, N.C. ¹	565-027	Clinical addition.....	April 1982.....	15,800
Lyons, N.J.....	604-064	120-bed NHCU.....	August 1982.....	18,200
Perry Point, Md.....	641-079	New laundry building.....	August 1982.....	18,500
Pittsburgh, Pa. (UD). ³	646-024	OPC addition.....	February 1982.....	22,680
Pittsburgh, Pa. (HD). ³	645-017	Laundry.....	October 1982.....	12,000
Pittsburgh, Pa.....	646-025	Centralized warehouse facility.....	October 1982.....	4,200
Richmond, Va.....	651-003	Automated transport system.....	May 1978.....	4,200
Salem, Va. ²	658-038	Renovate building 76 (intermed).....	April 1977.....	5,510
12 projects, total.....				<u>140,690</u>
Medical region 3—Southern				
Alexandria, La.....	502-058	Clinical improvements and relocate support function.....	June 1982.....	30,000
Biloxi, Miss. ²	520-056	Modernize various buildings (buildings and grounds).....	September 1982.....	87,300
Charleston, S.C.....	534-015	Clinical addition.....	April 1982.....	20,000
Lake City, Fla.....	594-036	OP and clinical addition.....	August 1982.....	6,000
Miami, Fla.....	546-014	120-bed NHCU.....	August 1982.....	16,000
Montgomery, Ala.....	619-020	OPC addition.....	September 1980.....	18,100
6 projects, total.....				<u>177,400</u>
Medical region 4—Great Lakes				
Battle Creek, Mich...	515-083	Renovate building 82 (first and second floors—patient privacy).....	February 1982.....	5,800
Chicago (Westside), Ill. ²	537-024	OPC addition/renovate buildings 11a and 11b.....	January 1982.....	40,500
Cincinnati, Ohio ²	539-026	Upgrade electrical distribution.....	March 1982.....	3,000
Cleveland, Ohio.....	541-021	Clinical improvement (surgical service relocated).....	April 1982.....	15,000
Hines, Ill. ¹	578-096	New warehouse/service building.....	October 1981.....	11,000
Hines, Ill.....	578-097	HVAC buildings 50, 51 and 53.....	February 1982.....	44,000
Tomah, Wisc.....	676-031	Modernize buildings 406 and 408.....	September 1982.....	5,400
7 projects, total.....				<u>124,700</u>

Footnotes at end of table

PROJECTS FOR REVALIDATION—MAJOR FISCAL YEAR 1984 REVISED AS OF APR. 6, 1982, BY MEDICAL REGION—Continued

[Dollars in thousands]

Medical center	Project identification	Project title	P.P. Comp.	Cost
Medical region 5—Mid-Western				
Cheyenne, Wyo.....	442-023	Exp./renovate building 1 (clinical function)	November 1982.....	\$7,700
Leavenworth, Kans. ²	686-062	F&S improvements (exit and sprinklers).....	March 1982	7,500
Leavenworth, Kans. ¹	686-060	208 domiciliary.....	July 1981.....	14,900
Minneapolis, Minn. ^{1, 3}	615-001	Replace hospital buildings.....	June 1982.....	294,000
Omaha, Nebr. ¹	636-022	OPC addition.....	September 1980.....	24,200
San Antonio, Tex.....	671-009	Supply warehouse and SPD.....	June 1979.....	5,800
Sioux Falls, S. Dak. ¹	438-020	Clinical and support service.....	October 1982.....	21,000
Waco, Tex.....	685-041	Construction-new dietetic building.....	March 1981.....	8,400
8 projects, total.....				383,500
Total less Minneapolis.....				89,500
Medical region 6—Western				
Amarillo, Tex.....	504-026	Addition/renovate—clinical support.....	June 1981.....	44,000
Fresno, Calif.....	570-019	Clinical addition (dental, surgical, RMS, et cetera)	November 1982.....	10,000
Livermore, Calif. ²	599-054	Fire and safety improvements.....	July 1982.....	3,500
Loma Linda, Calif.....	605-004	60-bed NHCU.....	October 1982.....	6,000
Los Angeles (WAD), Calif.	691-090	Renovate buildings 212, 214 and 217 for DOM	September 1981.....	17,300
Los Angeles (WAD), Calif.	691-098	120-bed NHC (conversion) building 213 phase II.....	March 1982.....	10,500
Martinez, Calif.....	612-018	120-bed NHCU.....	June 1982.....	14,400
Prescott, Ariz. ¹	649-047	200-bed DOM/60-bed NHC.....	March 1981.....	30,000
Roseburg, Oreg.....	653-027	OPC addition.....	February 1982.....	28,000
San Diego, Calif. ⁴	664-028	Emergency generator and conservation of energy.....	August 1979.....	2,800
San Francisco, Calif.	662-043	120-bed NHCU and parking.....	June 1982.....	14,400
11 projects, total.....				180,900

¹ Questioned by Inspector General.

² Fire/safety.

³ Split funded.

⁴ Added to fiscal year 1984 Revalidation List as a result of April 6, 1982 meeting between Jacoby, Salmond, West and Sullivan.

Note: Some of the projects listed indicate a preliminary completion date later than October 1982. These projects were included at the request of O. M. & S. as the potential exists prelims could be completed earlier in time for the fiscal year 1984 budget submission.

NEW CRITERIA FOR REVALIDATION OF THE VA MEDICAL FACILITY CONSTRUCTION PROGRAM

(Submitted by VA Administrator Nimmo)

As I indicated, our revalidation of the VA medical facility construction program will include new criteria. By that I mean we are obtaining and utilizing information in addition to that which was used in the development of the initial projections. In part, this includes some new construction design standards, such as revised design standards for increased energy efficiency. It also includes revised and updated analytical models, such as workload and demographic projects that are being used in the revalidation process. Such revised and improved devices will sharpen our revalidation work. Finally, we are obtaining additional facts which will provide a more current view of the existing circumstances surrounding the proposed projects.

Concerning availability to the public of this "new criteria," the design standards are already generally available to, and are used by, the construction industry. We would be happy to identify the specific standards used by the VA if there is interest in them. With regard to our working models, they too would be available upon request. Also, where our revalidation results in a substantive change in any of the major projects being reviewed, public notification of such changes may be provided through press releases. New facts arising from our revalidation process which influence such changes will be identified in the releases as appropriate.

Of course, in reviewing the projects involved, and in applying the new information to those reviews, we will be happy to work with, or keep advised, the members of your committee. In light of the nature of the aforementioned, we do not anticipate any publication in the Federal Register.

VETERANS' ADMINISTRATION,
Washington, D.C., March 31, 1982.

To: Mack Fleming, Chief Counsel and Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives.

From: William F. Sullivan, Associate Deputy Administrator for Logistics.

Subject: VA Facility Planning and Construction Committee (FPACC).

The following is intended to clarify the role of the Facility Planning and Construction Committee which Chuck Hagel and I discussed with you last week.

For your information, the Inspector General is no longer a member of FPACC. When FPACC was initially formed, the Inspector General was included on the Committee to facilitate keeping that office informed on the revalidation process and Agency policy discussions which might impact on the VA's planning and construction program. Based on a close reading of the Inspector General statute by both the VA's Inspector General and General Counsel, however, the Inspector General determined that neither he nor his staff should participate in the work of FPACC in order to preserve and retain the necessary independent status and judgment of the Office of the Inspector General.

The background of the formation of FPACC is as follows. On February 1, the Administrator appointed a top-level Executive Management Committee on Facility Planning and Construction composed of the Department and Staff Office heads of the Department of Medicine and Surgery, the Office of Budget and Finance, the Office of Construction, the Office of Program Planning and Evaluation, the Department of Memorial Affairs, the Office of Procurement and Supply, and the Department of Veterans Benefits. The VA's General Counsel, Inspector General and the heads of Congressional and Public Affairs, Reports and Statistics, and Public and Consumer Affairs were also invited to participate in FPACC in an informal capacity.

The function of FPACC is to serve as a deliberative body to generate ideas and serve as a discussion forum for improvements in the Agency's facility planning and construction program. The membership of FPACC was made broad to facilitate input from a variety of VA top management talents. While not every member of FPACC is experienced in health care planning or construction, all of them are professional managers who can bring their talents and expertise to bear on the FPACC mission and provide new perspectives for discussion.

Initially FPACC was tasked with directing an analysis of the VA facility planning and construction program. The role of FPACC was intended as that of a steering committee to guide VA staff talent in our construction program review.

On February 19, the Administrator announced that the Agency would undertake a comprehensive reassessment of the Major Construction projects planned for fiscal year 1984 and the outyears. As part of that effort, he further tasked several of the FPACC members with guiding the revalidation of the fiscal year 1984 projects.

This sub-group of FPACC is called the FPACC Revalidation Steering Committee and is composed of the following members of the full FPACC Committee:

The Deputy Administrator as the overall Chairman of FPACC;

The Associate Deputy Administrator for Logistics as the Vice Chairman of FPACC;

The Chief Medical Director due to the medical program and health care planning expertise of the Department of Medicine and Surgery;

The Assistant Deputy Administrator for Construction as head of the organizational entity that designs and constructs health care facilities;

The Assistant Deputy Administrator for Budget and Finance as that office is charged with evaluating the Agency's construction program and projects in terms of cost-effectiveness; and

The General Counsel to counsel the steering committee on any legal and/or contract issues and ensure adherence to statutory requirements.

I would note that all of the above individuals except for the Deputy, as part of their position at the VA, review and concur in construction projects at various stages of development.

In addition to the above, the following individuals serve on the Revalidation Steering Committee in an informal or ex-officio capacity. These individuals were included in order to keep them informed on the progress of the revalidation process. They do not serve in a decisionmaking capacity:

The Associate Deputy Administrator for Congressional and Public Affairs to ensure knowledge of the revalidation process in order to respond to Congressional and public inquiries;

The Assistant Deputy Administrator for Public and Consumer Affairs to enable him to respond to public and media inquiries;

The Assistant Deputy Administrator for Reports and Statistics to keep him informed of the need for statistical and demographic data in the revalidation process;

The Executive Assistant to the Deputy Administrator to assist the Deputy; and
The Executive Director of FPACC.

The existence of FPACC and the FPACC Revalidation Steering Committee in no way is intended to reduce in significance the role of the Chief Medical Director in recommending the priority of construction projects to the Administrator. Indeed, it is hoped that FPACC will help to foster better understanding of the construction project selection process among the Agency's top management and open the development of that process to creative discussion.

To date, FPACC has not been a voting body, and it is not envisioned that it will need to become one. In the area of facility planning and construction, affected Departments and Staff Offices will continue to play the roles they always have, with FPACC providing an opportunity for discussion of those roles and serving as a format for suggesting and discussing possible improvements.

I will be pleased to provide further information on the role of FPACC.

With kindest regards, I am

WILLIAM F. SULLIVAN,
Associate Deputy Administrator for Logistics.

DECEMBER 17, 1981.

HON. ROBERT W. EDGAR,
House of Representatives,
Washington, D.C.

DEAR MR. EDGAR: I am pleased to respond to your letter of December 9, 1981. I am forwarding a similar reply to Congressman Hillis.

The Department of Medicine and Surgery will immediately undertake a study of alternatives for providing outpatient services to the veterans of northwest Indiana. After I have had the opportunity to review the findings of this study, I will inform you of my decision.

You can expect to hear from me within sixty days.

Sincerely

ROBERT P. NIMMO, *Administrator.*

VETERANS ADMINISTRATION MEDICAL CENTER
PHILADELPHIA, PENNSYLVANIA

I. INTRODUCTION

On February 25-26, 1982, a regularly scheduled visit was conducted to the Ambulatory Care Center (ACC) located in downtown Philadelphia at 1421 Cherry Street. The following week (March 1-5, 1982), the Veterans Administration Medical Center, Philadelphia, Pennsylvania was surveyed. The purpose of these visits was to assess the quality, quantity, and timeliness of health care being provided to veteran patients.

Coordination: Notifications of the planned visit were forwarded to Mr. Barry L. Bell, Director; Mr. Edward T. Roak, Department Adjutant; Mr. John P. Ward, Department Service Officer; and Anne M. Harkins, Hospital VAVS Representative, The American Legion, Department of Pennsylvania.

Prior to the planned visit, meetings with the following Veterans Administration Central Office personnel were conducted:

Miss Marjorie R. Quandt
Assistant Chief Medical Director for Administration

Mr. A. Paul Morris
Deputy Director, Mid-Atlantic Region

Mr. Alan S. Hitt
Health Systems Specialist, Mid-Atlantic Region

Mr. Michael M. Larson
Director, Medical Administration Service

Miss Vernice Ferguson
Deputy Assistant Chief Medical Director for Nursing programs

Statistical Information pertaining to personnel on duty, personnel shortages, patients on the rolls, and operating beds is attached.

Professional Affiliations: This VAMC is affiliated with the University of Pennsylvania School of Medicine, the Medical College of Pennsylvania, and the University of Pennsylvania School of Dental Medicine. The Medical Center has numerous other academic and training agreements in allied health and administrative disciplines including Pharmacy, Nursing, Occupational, and Physical Therapy.

Discussions with top management indicated that equal partnerships exist with the VA and the medical school affiliations. It was further reported that the VAMC is allowed to select people to fill their vacancies, which was reportedly not the case in previous years.

Hospital Accreditation: A June, 1981 survey conducted by the Joint Commission on Accreditation of Hospitals resulted in a full two year accreditation. No major deficiencies were noted.

MISSION OF MEDICAL CENTER

The Philadelphia VAMC was constructed in 1952 and is located in the fifth largest city in the United States. Over 60% of Philadelphia VAMC veteran patients live within the city limits of Philadelphia. Most other veteran patients live within a 25 mile radius, although significant numbers of veteran patients come from all areas within the Medical District. Philadelphia is associated with VA Medical District 4 which is comprised of seven VA Medical Centers in three states.

This 478 bed Medical Center provides primary, secondary, and tertiary care in varied subspecialties for acute medical, surgical, neurological, rehabilitation medicine, and psychiatric patients. Additionally, there are inpatient and outpatient programs in alcohol, drug, and hemodialysis. There is also a Hospital Based Home Care (HBHC) program.

The geographically separated Ambulatory Care Center (ACC) provides primary care, compensation and pension examinations, and specialized outpatient services including a day treatment center and a mental hygiene clinic.

The 421 operating beds and Fiscal Year 1981 statistics are as follows:

	<u>Surgical</u>	<u>Medical</u>	<u>Neurology</u>	<u>RMS</u>	<u>Psychiatry</u>
Operating Beds	184	162	12	20	43
Turnover Rate	148.8%	332.2%	114.3%	79.2%	141.1%
Occupancy Rate	82.8%	83.5%	116.7%	80.0%	85.3%

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: According to the Director, both staffing and funding should be increased. Although an increased budget was realized, it still did not keep pace with the inflation rate. Eighteen employees will be reduced through attrition to meet daily supply needs.

Space throughout the facility is grossly inadequate, and getting worse. According to the Space and Functional Deficiency Identification System (SFDIS), VAMC Philadelphia has been identified as the third worst Medical Center in the system in regard to space and function. Although several projects over the years have enlarged the original building, no additional space has been provided for patient care activities. The Five Year Facility Plan for Fiscal Year 1984 has requested a Clinical Addition Project. It is of vital importance to retain this project on schedule.

The outpatient area at the hospital was originally designed for less than 20,000 visits per year. Last fiscal year, over 169,000 visits were realized in this area. A project was recently awarded for 1.3 million dollars and 147 man/months, to alleviate congestion in this area. As of late, however, the allowed man/months were drastically reduced to approximately 37 man/months. The first phase of this project is close to completion and it is expected that this project will end here unless additional man/months are reinstated. Management foresees the need for a minimum of 100 man/months to complete this urgently needed project.

Each year, this facility is falling further behind in replacing and upgrading equipment. This is due to inadequate equipment funding. Management reported that if this trend continues, serious consequences in the quality of care provided to

veterans will result in less than five years.

As a last resort before having to close wards, management implemented a salary increase for Registered Nurses and initially paid for it out of their budget. A forty-five day lag period in hiring was started to help absorb some of the lost monies until VACO reimbursed this facility. Although reimbursement was finally received, it was only for this fiscal year. It is unknown if money will be provided next year. If money is not authorized, management will have to hire less nurses, and, subsequently, close beds. It is vital that VACO fund this pay raise on a recurring basis.

A minimum of \$250,000 is expended annually to obtain CT scans on a contract basis. This does not take into consideration the cost of transportation which was reported to be a minimum of \$40 each way. Delays of as much as 3 days are also encountered. Because of the costs involved, CT scans have to be highly justified, indicating that some veterans that should have these scans are not receiving them. The inconvenience and safety factors are significant as well.

The need for a minimum of 740 parking spaces has been identified. Currently, 690 slots are available. At the present time, there are no solutions in sight. A residual benefit to the parking problem is that employees must get to work early in order to get a parking space.

Professional Services: The Chief of Staff (COS) related that he is satisfied with both the quality and quantity of the professional staff. The majority of the physicians are board certified.

One of the major concerns of the COS is the lack of equipment money. Often-times, the emergency replacement of a large piece of equipment virtually eliminates the entire budget for the year. A case in point would be the recent need to replace the ultrasound unit on an emergency basis. Rather than establishing a contract, at \$200 a procedure, this equipment had to be replaced at an estimated cost of \$91,000.

Assistant Director: The Assistant Director stated that there were no key vacancies in those services under his supervision.

It was reported that, with very little notice, the Government Services Administration (GSA) cancelled their security coverage at the Ambulatory Care Center (ACC), located downtown. Consequently, the VAMC had to take corrective actions. Two personnel from the hospital's security force were assigned to the ACC. As of late, VACO has provided \$50,000 for the purpose of hiring contract security personnel through GSA. It is worth noting again that GSA is not responsive to the needs of their tenants. The overall ambience of this GSA building certainly supports this statement.

Security Service has an authorized ceiling of 24 personnel. Currently, there are 3 vacancies. The Chief stated that an additional 6 officers are needed to provide adequate, 24 hours a day coverage.

As a result of insufficient staff, expensive video equipment is virtually useless due to the inability to man the panels. Cameras scan various parts of the hospital, but oftentimes, no one is available to monitor the screens.

Although officers at this facility receive an entry grade of GS-5, the Chief

feels he has to accept marginally acceptable officers at times because of inadequate pay.

The Chief expressed the need for ongoing continuous training for his officers. The orientation training at Little Rock is inadequate. Reportedly, this basic training course does not sufficiently address areas such as interpersonal communications, public relations, or the handling of disturbed patients.

A partial list of incidents at this facility includes bomb threats, auto thefts, drug patient disruptions, and weapon confiscations. The Chief reported that 300-350 weapons are confiscated each year.

A recent security breach, in the form of a lost master key, has dictated that many of the locks in the basement be changed. Although the key opens virtually every door in the hospital, the basement was the area hardest hit with thefts.

REGIONALIZATION

No complaints were received pertaining to the level of cooperation between the medical centers in Medical District #4. Although growing pains are anticipated with the MEDIPP process, management is confident that the end product will ultimately improve care and save dollars. The Director at this VAMC is the District Director. VAMC Philadelphia is located within the Mid-Atlantic Region.

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

Personnel Service coordinates a 3 phase orientation procedure for new Government employees. During the first phase, employees are briefed on the policies and procedures within the Medical Center. The second phase is conducted by the employee's supervisor and includes orientation to the work site. Approximately one month after being hired, new employees are required to attend a group orientation session. Topics pertaining to specific rules and regulations, safety, the union, and security are discussed at this time. Additionally, introductions to top management are furnished during this session.

AMBULATORY CARE CENTER (ACC)

The building utilized for this Center is a Government Services Administration (GSA) building. The location is 1421 Cherry Street, Philadelphia, Pennsylvania.

The overall ambiance of the ACC does not meet VA standards. Paint is peeling off the walls, carpets are bare, torn, and necessary maintenance tasks are neglected. More serious than the esthetic problems are the fire and safety shortcomings. Fire extinguishers were observed to be in need of recharging and most are not conspicuously located along normal paths of travel. An inside fire escape has been cited on several inspections as to its ineffectiveness in the event of an emergency. Although no leaks were personally observed, personnel reported problems in this area as well. The GSA is not responsive to the Medical Center's needs.

Along with not creating an environment conducive to good outpatient care, this Center's appearance hinders recruitment efforts for professional staff.

Parking is virtually non-existent for outpatients visiting this Center. Facilities for the handicapped person are minimal. It is certain that those few restrooms with the handicapped person insignia on the door, do not meet the criteria.

Many of the restrooms have stairs leading to them.

The hours of the ACC are 8:00 a.m. to 4:30 p.m., Monday through Friday. During Fiscal Year 1981, 95,120 visits were recorded. The majority of these visits (86.3%) were from service-connected veterans.

The following is a list of the clinics offered at the Ambulatory Care Center:

Audiology	Hypertension	Optometry
Cardiology	Medical	Opto-Neuro
Day Treatment	Neurology	Orthopedics
Dental	Psychiatry	Podiatry
Dietetic	Mental Health Clinic	Prosthetics
Geriatrics	Ophthalmology	

Audiology and Speech Pathology Service: Morale problems within the Audiology and Speech Pathology Service were in evidence. Discussions with the Chief and personnel of this service revealed that most frequently mentioned problem was with scheduling. Currently, scheduling is controlled by the front office at the hospital. The present schedule calls for 32 patients a day. It was mentioned that one-half of this work load would be too much. Consequently, it was expressed that even at this point examinations are being rushed to meet the numbers. Although the figures look good, the quality is lacking. It is fortuitous that requests from veterans do not equate to 32 appointments a day at this time. Discussions with management, during the Summation Conference, were generated pertaining to this arrangement. The Director stated that in the future, if there are enough cases to fill this schedule, an adjustment will be made.

Another demoralizing factor involves training slots. In the past, this service has requested and received 4 trainees. This year, however, the front office allowed only two, and submitted the reduced request without first consulting with the Chief. The COS reported that he wanted these two additional slots for Psychology trainees, and took them from this service. The COS further stated that he could not exceed the hospital-wide allotment for trainees, and, consequently, had to make this adjustment.

Medical Records Section: After receiving scattered complaints pertaining to the medical records, a meeting was conducted with the Supervisor of the records section. The major complaint was the inability of this section to insert laboratory results in the patients' files on a timely basis. Oftentimes, this information is not in the file after a month's time. Consequently, patients sometimes return for a second visit and are requested to have duplicate laboratory work done because the physicians are unaware of the first request. Management later reported that this concern will be fully investigated and corrected.

Prosthetics Service: A meeting with the Chief of Prosthetics revealed that internal issues are distracting the Chief from his normal duties. Because it was learned during the Summation Conference that this Chief will be transferring in the near future, elaboration on this subject would not be worthwhile.

Prosthetics Service did express satisfaction with the workmanship of the brace and limb makers. Contract items are occasionally substituted during a backlog period. Delays are oftentimes encountered at the end of each quarter, while awaiting a new budget period. The Chief reported that the longest waiting period veterans have had to experience is two weeks. Previous problems pertaining to purchasing

eyeglasses under contract have been eliminated. By curtailing the need of buying non-contract eyeglasses locally, an estimated savings of \$50 per set of eyeglasses has resulted. An annual savings of \$50,000 is expected.

Restoration Clinic: According to the Chief of the Restoration Clinic, our needs are minimal for this two man operation. Numerous positive reports and comments pertaining to the operation of this Clinic were confirmed during the survey.

Pharmacy Service: During the Fiscal Year 1981, the AOC Pharmacy processed 188,562 mailout prescriptions and 107,896 outpatient prescriptions. Personnel required to work overtime in order to process the mailout prescriptions on a daily basis. Prescriptions filled at the window were reported to involve an average waiting time of 30 minutes. Veterans interviewed revealed this time to be unrealistic. Most often, waiting times in excess of 55 minutes were recorded.

The Supervisor of the AOC Pharmacy reported one vacancy for a technician. It was further reported that staffing is sufficient only if everyone is present. One person on leave disrupts the entire operation and increases waiting time.

Dental Service: The Associate Chief of the AOC Dental Service expressed minimal needs. One area of concern was for a full-time hygienist. The hygienist currently being utilized is on loan from a research project for three days each week. A remodeling project for this Dental Suite is presently being finalized. This project will include a new waiting area, new dental chairs, and substantial improvements within the dental laboratory.

Laboratory Service: The Supervisor of the Laboratory stated that justification for one additional technician is solid. Currently, expensive tests, that could be accomplished in house, are being contracted to the community due to the lack of manpower. Environment improvements are needed in the Laboratory.

Radiology Service: Radiology equipment is in jeopardy due to the inability to maintain a proper temperature during summer months. Air-conditioning needs must be addressed to prevent further deterioration of the equipment and also morale of the personnel.

Discussions with Laboratory and Radiology personnel highlighted the need to improve communications, supervision, and motivation techniques from the parent facility. The general consensus was that the hospital services get priority when dealing with staffing and general needs. The lack of someone in charge was mentioned on several occasions within these services. Staffing needs include one technician for each service. No significant backlogs were reported.

Psychiatry Service-VAMC Coatesville, PA: A meeting was conducted with the psychiatrist-in-charge of the Coatesville-Jefferson program located at the Ambulatory Care Center. This program was created by the joint effort of four institutions: the Coatesville Veterans Administration Medical Center, the Department of Psychiatry and Human Behavior of Thomas Jefferson University, the University of Pennsylvania, and VAMC Philadelphia. This program provides outpatient treatment primarily for those patients discharged from VAMC Coatesville that are from the Philadelphia area. Basically a teaching clinic, this program involves six third year Residents and five fourth year Residents who examine patients under supervision. The VA staff assigned to VAMC Coatesville consists of one full-time, and seven part-time Psychiatrists, two part-time Psychologists, one Social Worker, and two receptionists.

Although staffing was deemed adequate for the present annual work load of 9000 visits, calculations indicate that 12,000 visits will be realized next year, at which time, additional staff will be warranted.

Mental Health Clinic-Day Treatment Center: The Associate Chief of Psychiatry reported 2600 active patients in the Mental Hygiene Clinic and 46 patients in the Day Treatment Center. Staffing for these areas was reported to be sufficient.

Psychology Service: The Chief of Psychology did, however, express the need for two additional Psychologists. It was reported that there is only 1 Psychologist in the Medical Center proper. Five Psychologists are assigned to the Substance Abuse Program. Requests in the past have been fruitless.

Post-Traumatic Stress Disorder (PTSD): Since September 1981, 20% of all requests for C&P Examinations in Psychiatry Service have been for Post-Traumatic Stress Disorder. Interestingly enough, an average of 110 requests per month are from WWII veterans. The Associate Chief reported that oftentimes the symptoms do not surface until after the veteran retires from his job. It was further reported that it is difficult to convince the adjudication board of this fact.

Ongoing counseling sessions with the Psychiatry staff seem to have alleviated prior concerns pertaining to the stressor not being adequately identified. It was reported that even severe PTSD recipients receive only a 30% disability. Although improvements have been made in obtaining the veterans' claim folders from the Regional Office, further improvements would be welcomed, according to the staff at the ACC. This facility has a specific program for Vietnam veterans and PTSD, operated by a multidisciplinary team. Members of this team include 2 Psychiatrists, a Psychologist, a Psychiatric Nurse, and a Social Worker. Statistics gathered from the Regional Office show that a denial rate of 44.9% for the 330 PTSD claims to date. The average disability percentage assigned was reported to be 25 percent.

Veterans interviewed at the ACC complained of long lines. Often, the veteran is required to wait in a line for 10-15 minutes only to discover they have to go to another section first. Some excessive waiting times were recorded. A few complaints about having to bounce back and forth between the hospital and the ACC were also noted.

ADMISSIONS, OUTPATIENT CLINIC, AND AMBULATORY CARE SERVICE

A vacancy currently exists for the Associate Chief of Staff for Ambulatory Care (ACOS/AC). The responsibilities of this individual include the ACC as well, indicating the serious need to fill this vacancy as soon as possible.

This service is critically short of space. As previously mentioned, the proposed renovation project is urgently needed. Maximum utilization of the health care providers is not possible within this service. The lack of adequate space contributes to the occasional excessive waiting times that were recorded. Personnel in the evaluation area, where unscheduled appointments are directed, admit that waiting times are unacceptable on busy days.

Previously mentioned problems pertaining to medical records were confirmed by personnel working in this area, veterans being treated, and observations, made by the surveyor. Problems with scheduling were mentioned several times, which would support management's desire to implement computerized scheduling.

Although reports were received while interviewing outpatients about excessive waiting times, it appears long waiting times are the exception rather than the rule.

MEDICAL ADMINISTRATION SERVICE

During Fiscal Year 1981, this VAMC was funded for 180,099 outpatient visits. During that time, 169,459 outpatient visits were recorded. Approximately 10% of these visits were from service-connected veterans. Outpatient visits at the ACC totalled 95,120 of which 86.3% were from service-connected veterans.

The following figures designate the number of service-connected (SC) and nonservice-connected (NSC) patients in each bed category.

<u>Bed Category</u>	<u>SC</u>	<u>NSC</u>
Medicine	29	83
Surgery	38	114
Psychiatry	13	15
Neurology	7	8
Rehabilitation Medicine	2	12

Numerous problems pertaining to medical records were discussed at length with the Chief of MAS. Undoubtedly, the biggest challenge this newly assigned Chief must address, pertains to medical records. Numerous corrective actions, including various reassignments of personnel, have already been implemented and will be explained later in this report.

Historically, MAS at this facility has had difficulty retrieving patient medical files. As a consequence, MAS has lost its credibility when it comes to providing the Physicians with the patients' records. Subsequently, Physicians start hoarding the files, sometimes to the point of setting up their own filing system. Obviously, this further compounds the problem, not to mention the legality aspect.

According to the Chief of MAS, the present medical records retrieval rate is only 65-75 percent. It is both unacceptable and possibly dangerous to treat veterans without their medical records available. Additionally, if on the succeeding visit the "lost" file is the one pulled, information from the preceeding visit is not available to the Physicians. Along with the threat of subjecting the veterans to duplicate tests, the overall continuity of care is lost. It is worth noting that some veterans have three or four separate medical records. This is because of the aforementioned problems and the fact that the ACC is located downtown. Discussions with an American Legion official, who has been an outpatient at this facility for years, revealed that he has a minimum of four different files.

As previously mentioned, the Chief of MAS inherited these problems less than 6 months ago. After MAS has reestablished their credibility, the following corrective actions should eliminate the major concerns with medical records.

1. Several personnel changes within the MAS.

Comment: Internal problems over the years within the Medical Information Service (MIS) have hopefully been eliminated. Additionally, new personnel will be assigned as the Chief of Ward Administration and Chief of Ambulatory Care for MAS positions.

2. Consolidating MAS into one general area.

Comment: Completion of this station project is expected within 6 months. This will considerably improve the overall effectiveness of this service.

3. Relocating and upgrading the medical file room.

Comment: Management reported that within one year, the medical file room will be relocated to the basement. This will provide much needed space and open shelving. Currently, rotating medical files are being utilized, seriously restricting individual work areas.

4. Highlighting and narrowing the responsibilities of the medical file clerks.

Comment: In conjunction with stressing the importance of their jobs, the Chief has assigned various clinics to individual medical file clerks. When medical records for a certain clinic cannot be located, it is the responsibility of one particular medical file clerk. Their individual success, or lack thereof, is taken into consideration when proficiency reports are written.

BED SERVICES

Medical Service is responsible for 162 operating beds. Ten MICU beds are included in this total. MICU beds were reported to be sufficient by the Chief and his associate.

The Chief and the Associate Chief stated that they are completely satisfied with all aspects of their service. Although numerous complaints, pertaining to the lack of support from the Laboratory, were registered by the other service chiefs interviewed during this survey, this service reported complete satisfaction in this area. However, in regards to Nursing Service, the Chief expressed the need for additional support.

Surgical Service was reported to be adequately staffed in all areas except nursing. As a result, 14 beds have been closed on one surgical ward. Additionally, two surgical intensive care unit beds are out of service, leaving 8 operating beds in this unit. Including the SICU beds, a total of 184 operating beds are maintained.

Six operating rooms were deemed marginally adequate by the Associate Chief. All six are utilized for a minimum of 8 hours per day. An upcoming renovation project, addressing air-conditioning and electrical needs, will allow this service to utilize only 4 OR's for a period of time.

Last Fiscal Year this service performed 2300 surgical procedures. All types of surgery are performed here with the exception of transplant and open heart surgery. Contracts for open heart surgery have been established with the University of Pennsylvania and other community sources. Plans are currently being formulated to utilize VAMC East Orange, NJ for future open heart cases.

The Associate Chief related that problems are oftentimes encountered when attempting to obtain CT scans. Head scans are readily obtained, but body scans generally involve delays of at least 3 days.

Psychiatry Service: This 28 bed service has submitted a long range proposal

to expand the number of beds by 1990. Tentative plans indicate that 72 beds are projected. This would include beds for the Substance Abuse Program as well.

Patients requiring long-term Psychiatric care are generally transferred to VAMC Coatesville. The Chief reported that meetings are ongoing to attempt to facilitate transfers. It was further reported that it is sometimes difficult to locate a bed during the night shift or on weekends for service-connected veterans. Additionally, the Chief reported that similar problems are encountered when a violent patient is admitted at night if there are no beds available. Again, the normal procedure is to admit this type of patient just long enough to transfer him to VAMC Coatesville. However, if a violent patient is admitted when there are no available beds, the Chief reported that this patient must be kept in the emergency room overnight until a transfer can be arranged. These reasons alone justify increasing the bed capacity within this service immediately. To wait until 1990 would be insane and reeks of danger.

The Chief expressed dissatisfaction with the current arrangement of having the outpatient activities located downtown in the ACC. Obvious benefits to include better staff utilization would result if this service were unified.

Substance Abuse Program: It was reported that this facility is a center for research, where various methods and studies are conducted. A 15 bed inpatient unit is operational. The vast majority of the inpatient treatment is detoxification. The staff reported that only 2 or 3 veterans receive rehabilitation training on the unit. The remainder receive this training while on outpatient status.

Approximately 225 alcohol outpatients account for 1200 visits a month. It was reported that there is not a time limit set for these patients' aftercare. Usually they are followed for 2 or 3 years, while the number of visits are gradually decreased. Although both aspects of this program attract an inexhaustable number of patients, the need to provide treatment for alcoholic patients exceeds the need for drug patients. The possibility of increasing the resources for treatment of alcoholic patients should be investigated.

The use of Anatabuse is encouraged and taken by approximately 25% of the outpatients. It was further reported that some patients are required to take Anatabuse, if medically feasible. Approximately 70% of the patients are successfully referred to Alcoholics Anonymous. Additionally, it was related that only 25% of alcohol abusers treated are employed. The average age of alcoholic patients was reported to be 40 years old.

It was noted that approximately 10% of the alcohol patients are readmitted within 6 months of discharge. The Coordinator stated that there is not a limit as to the number of times a former patient can be readmitted. He further stated, however, that after 2 or 3 failures, every attempt is made to get the veteran in a different aspect of the treatment program. Only 10% of the patients are involved in family therapy.

Approximately 350 drug patients are involved in outpatient treatment. It was reported that these patients amass around 80,000 annual visits. No time limits are established for these patients. Some have been receiving treatment for over eight years. It was further reported that 50%-60% of the patients enrolled in this program have been treated for more than one year.

The average age of drug patients is 32 years old. Reportedly, 50%-60% are

employed. Five percent were reported to be involved in family therapy. As is the case with alcohol patients, a more intense approach toward family therapy appears warranted.

Drug abusers can be readmitted forever, according to the Coordinator. After the fourth or fifth readmission, attempts are made to involve the veteran in longer term treatment, usually at VAMC Coatesville, or in a community narcotic antagonist program. Five to ten percent of these patients have to be readmitted within six months.

Staffing for the total program was reported to be adequate. Inpatient staffing was reported to be two Physicians, 7 Registered Nurses, and 4 Rehabilitation Technicians. The outpatient staff complement is as follows: 4 Physicians (part-time), 5 Psychologists, 3 Pharmacists, 2 Nurse Practitioners, 2 Social Workers, 12 Rehabilitation technicians, 3 Clerk Typists, and 1 Secretary. The need was expressed for one additional counselor for both the drug and alcohol aspect of this program. No request has been made to management. The staff had mixed blessings pertaining to the one recovering alcoholic and two ex-drug addicts assigned. Assets reported were a high level of rapport and closeness in understanding. Liabilities include lifestyle traits being carried over into training.

Statistics pertaining to the success rate could not be quoted. It was stated that "on the average, patients improve in their functioning."

This program generates many professional articles on substance abuse treatment. However, this should not be their primary mission. Treatment modalities provided to veterans should support individual needs, not future research articles.

Methadone Maintenance Program: The building utilization for dispensing methadone was recently renovated. A VA police officer controls admission to the dispensing area. Two areas are available; one for waiting, one for actual consumption, and other required particulars. Last fiscal year, over 74,000 drug related outpatient visits were recorded.

It was stated that the quantity of Methadone dispensed to individual veterans is never reduced blindly. The patient must agree to receiving gradual reductions.

Neurology Service: Expansion of this 12 bed service cannot wait until the projected date of 1990. As a result of an insufficient number of beds, many patients are transferred to other VAMCs or are taken care of by other services within the hospital. Management reported that there are not any expansion plans until 1990. During Fiscal Year 1981, this service realized a 116.7% bed occupancy rate.

The Chief is satisfied with staffing at both the ACC and the hospital. Recruitment is ongoing for a full-time Neurologist. The Chief expects this vacancy to be filled before July of this year.

Previously mentioned delays with obtaining CT scans on a contract basis were confirmed by the Chief. Additionally, CT scans are obtained on a limited basis. Three hospitals provide this service for CT scans. The main supplier is the University of Pennsylvania.

Rehabilitation Medicine Service (RMS) maintains 20 beds. The Chief stated that this was a sufficient number for the present work load.

Reportedly, a sufficient number of therapists are available. Staffing shortages include clerical personnel and nurses. Because RMS is not considered life threatening, nurses are often pulled from this service to cover other areas of the hospital.

This service recently met VACO qualifications for a Rehabilitation Coordinator. Consequently, the Chief is in the process of putting together a position description to be submitted to management. Management implied that they would be supportive of this position.

Recreation is a separate section under RMS. Staffing consists of one section chief, one recreation therapist, and one aide. The recreation therapist provides part-time coverage to the Day Treatment Center, located at the ACC. Although staffing appears inadequate, it was reported to be sufficient.

This service is critically short of space. It was reported that inadequate space within this service always results in a JCAH citation. Equipment was observed to be borderline adequate. Problems with obtaining replacement equipment are continuous.

Modalities offered include Physical, Occupational, Recreation, and Corrective Therapies. The one corrective therapist operates a handicapped driver training program throughout the Region. The automobile utilized for this program was reported to be unsafe. High speed avoidance maneuvers cannot be taught with this automobile because it is unsafe. Before the inevitable occurs, this automobile must be replaced.

MEDICAL SUPPORTIVE SERVICES

Pharmacy Service at this facility was reported to be the fourth largest within the VA system. During Fiscal Year 1981, this Pharmacy processed 36,829 mailouts and 257,218 outpatient prescriptions. The average turnaround time was 2 days for mailouts and 40 minutes for prescriptions filled at the window. This pharmacy also dispensed 97,348 doses of Methadone during Fiscal Year 1981.

The Unit Dose Distribution System and a centralized intravenous additive program were recently completed. The Chief stated that the 21 FTEE received to support these programs is adequate. As a point of interest, it was reported that the hyperalimentation program originated at this VA Medical Center.

Space is a problem at both pharmacies. Satellites, set up for Unit Dose in the main hospital, are located on the 3rd, 6th, and 8th floors.

Computerization capabilities would be a tremendous asset to this busy pharmacy. The Chief reported that he has reviewed and researched various systems. Some inexpensive systems are available that would easily meet the needs of this pharmacy. A computer would eliminate the concerns about veterans receiving prescriptions at the ACC in the morning, then duplicating these prescriptions at the hospital in the afternoon. In-station safeguards are in effect to prevent this but are not guaranteed.

Nursing Service reported vacancies for 19 Registered Nurses and 10 Licensed Practical Nurses. Currently, fourteen surgical beds and two SICU beds are closed because of staffing shortages.

A recent salary increase and recruitment authority for LPNs has improved recruitment and retention for Licensed Practical Nurses.

As previously mentioned, VACO has paid for the recently implemented salary increase for RNs only for the remainder of this year. It is unknown what will happen next year, according to the Director. The Medical Center cannot afford to absorb any part of this pay raise. Consequently, if VACO does not fund this salary increase on a recurring basis, management will be forced to reduce the number of nurses, and ultimately have to close beds.

Social Work Service: The acting Chief expressed the need for two additional social workers. One worker is needed to improve coverage within the medical service. The other worker would be utilized in the outpatient area, referring veterans to community resources.

There are currently 20 nursing homes in the area with which the VAMC refers contract nursing home patients. Presently, 118 veterans reside in these homes at an average daily cost of \$44.68. Although the demand is high for personal care home placements, only 6 veterans are supervised in 3 homes. The acting Chief stated that this residential home care program will be expanded as staffing limitations allow.

Laboratory Service is dangerously short of staff. Seven vacancies for laboratory technicians and technologists are difficult to fill due to inadequate starting salaries. As a result, morale within this service is at an all time low. Additionally, personnel are constantly being juggled around to cover various sections. Allowing only compensatory time in lieu of overtime is also demoralizing.

According to the acting Chief, recruitment is ongoing for a Chief of Laboratory Service. This vacancy has existed since April 1981. The Chief of Staff reported that a candidate for this position has been identified.

This active service generates two million procedures per year. Last year, 7 million tests were accomplished. Space is restrictive, but should be improved with a future renovation project scheduled for 1984.

Turnaround times on most tests are more than doubled, according to the acting Chief. Confirmation of this was received from various professionals throughout the survey.

Although 5 technicians are the normal staff complement for the blood bank, only 1.75 personnel are presently on board due to the aforementioned vacancies. The supervisor of this complicated sector was most explicit about how critical this situation is when considering veterans' safety. Top management related that this supervisor grossly overstated her case when she stated that in the event of an emergency, the patient will die. This supervisor also related that she would not want her family members at this facility under these circumstances.

Another result of insufficient staff within the Laboratory Service is the need to pay for outside tests. In the last 3 months, \$56,000 was expended for tests that could have been accomplished at this facility with additional personnel.

It was reported that VACO criteria for getting autopsy reports reviewed, typed, and placed in the veteran's file is 60 days. During a survey of the Laboratory, a stack of files were discovered, representing a 10 year backlog with these

autopsies. Although some sources at the hospital tried to emphasize that "the patient is dead, what does it matter?", important factors relating to autopsy reports justify the criteria set up by VACO. More often than not, survivors are reluctant to have their loved ones "cut up" during an autopsy. Consequently, it requires a great deal of pleading and promises to secure their permission. Most important, however, is these autopsy reports act as part of the quality control system, giving a final, objective accounting. Additionally, some administrative actions depend on the outcome of these autopsy reports.

One other area of concern was uncovered in the Laboratory. This involves the work load of the Cytology Technician. The College of American Pathologist (CAP) work load requires a maximum of 60 slides per day, per cytology technologist. Between January 1 and February 17, 1982, CAP standards show she should have examined only 1860 slides. Records show that during this period, this person examined 13,320 slides. Obviously, this heavy work load impairs her accuracy. The bottom line is that any mistake will be detrimental to the veterans' health. A recent audit revealed (only) one false positive and one false negative. According to the acting Chief, the "mistake" of a false positive could mean the veteran's lung may be removed unnecessarily. The false negative means treatment will be neglected because the problem is not identified.

SPECIAL PROGRAMS

Hospital Based Home Care (HBHC): Personnel interviewed in this program implied that problems are encountered whenever their case load exceeds 55 patients. The current case load is 61 patients. Additionally, there are 10-12 veterans awaiting involvement in this program. Three of these veterans are terminally ill patients.

Statistics reviewed showed 41 discharges from this program last fiscal year. Nineteen percent of these were referred to outpatient treatment, 5% were admitted to Nursing Homes, 44% died at home, and 32% required readmission to the hospital.

To support a case load of 70 patients, two additional home technicians, 1 Registered Nurse, and additional support from a Physician would be required. Management reported that VACO would have to allocate these resources.

With the exception of one person, this team appears extremely dedicated and compatible. Internal adjustments are being requested from the Chief of Social Work to perfect this team. It was reported that Physician support is the contributing factor in making this program work as well as it does.

A radius of 30 miles is allowed. Reports were received pertaining to the unsafe areas that must be visited. Most often, two people try to visit these areas together.

ANCILLARY SERVICES

Dietetic Service: A renovation project, remodeling the entire kitchen, is nearing completion. The acting Chief related that new equipment will be included in this project. Future renovations include a project in the basement to increase refrigerator and freezer space.

The acting Chief expressed satisfaction with the current staff complement

The only vacancy reported was for the Chief of this service.

An average of 310 veterans receive 3 meals daily. Sixty-five percent of these diets are modified. The raw ration cost was reported to be \$3.27 for last quarter. This service is providing approximately 95% convenience foods.

The only reported need expressed by the acting Chief and her staff was for a full-time nutrition clinic. Currently, this clinic is conducted in a haphazard manner. There is not a room assigned for it, nor are there designated hours. As of late, this clinic has been operational only about 2 hours a day. The need to provide this service 8 hours a day has been justified.

Veterans Administration Voluntary Service (VAVS): There are 35 organizations on the VAVS Committee. These organizations are represented by 304 regularly scheduled volunteers. These volunteers contributed 60,000 hours for FY 1981. The American Legion currently has 10 volunteers and the American Legion Auxiliary has 17 volunteers. The American Legion volunteers donated 6804 hours and the Auxiliary amassed 4909 regularly scheduled hours for Fiscal Year 1981.

The American Legion VAVS Representative is Anne M. Harkins and her Deputy is John Thain. The American Legion Auxiliary VAVS Representative is Catherine Rotay and her Deputy is Francis Urwiler. The American Legion Auxiliary has a representative and a deputy at the AOC as well. These individuals are Margaret King and Maluina Dickerson, respectively.

III. CONCLUSIONS

The two biggest obstacles preventing this facility from providing better patient care pertain to medical records and the Laboratory. These two problems identified by this reporter hamper the delivery of a higher degree of patient care. Emphasis on immediate management assistance in these two areas is desired. When this is accomplished a higher quality of veteran-patient care will be realized on a more timely basis.

As previously mentioned, the new Chief of MAS has already implemented corrective actions pertaining to the medical records problems. Alleviating these problems will be difficult and time consuming. However, all indications are that the proposed solutions are valid and should eliminate most concerns in this area.

Insufficient staff within the Laboratory is the cause of most of the problems in this service. Recruitment is in effect, but difficult because of inadequate salaries. It is difficult to say if a more vigilant recruiting effort would improve this situation. Regardless of the true reason, something must be done to increase the staff in this service.

Indications are that this facility is on VACO's list for CT Scanners. Justification is readily apparent. Any further postponements will not only be costly, but detrimental to veterans' welfare.

Serious space deficiencies were in evidence in virtually every patient treatment service. The proposed (FY 1984) Clinical Addition would eliminate the major concerns pertaining to insufficient space.

However, an ongoing project, if completed, will improve space within the ambulatory care area via the domino effect. Because of the recent reduction in man/months, it is the opinion of management that completion of this project cannot be accomplished. Requests have been forwarded to VACO for the reinstatement of additional man/months to allow this urgently needed project to continue.

The Ambulatory Care Center located downtown is far below the standards of any VA facility visited. The issue is no longer a matter of moving out of this building to be closer to the hospital, but simply moving out of this building.

IV. RECOMMENDATIONS

1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director place the Clinical Addition Project as outlined in the current comprehensive 5 year plan into the new updated comprehensive 5 year plan that is presently being formulated.
2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director guarantee funding on a recurring basis for the Special Salary Rate Increase for Registered Nurses.
3. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director immediately authorize and provide funding for the procurement of a CT scanner.
4. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director immediately authorize and provide funding for computerization of the Pharmacy Service.
5. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize an onsite visitation from VACO to explore the possibility of relocating the Ambulatory Care Center out of this dilapidated 80 year old GSA Building. The new facility must meet the future needs of the veteran population and additionally provide ample parking.
6. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director reinstate the withdrawn man/months to allow completion of the Medical Center outpatient area project.
7. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize the purchase and funding for a computerized scheduling system.
8. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director confirm the need for additional beds within Neurology and Psychiatry Services and take corrective action.
9. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director procure a new automobile to be utilized for driver training for the handicapped as outlined in the body of this report.
10. It is recommended that the Medical Center Director and the Chief of Staff monitor continually the activities pointed out in the body of this report and the conclusions in regard to providing better patient care in the medical records and Laboratory Services.

BEST COPY AVAILABLE

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION Philadelphia, PA DATE OF INFORMATION February, 1982
 MEDICAL CENTER DIRECTOR BARRY L. REIL
 ASSISTANT MEDICAL CENTER DIRECTOR JAMES J. FARSETTA
 CHIEF OF STAFF GEORGE E. MC NEAL, JR., M.D.
 MEDICAL SCHOOL AFFILIATION University of Pennsylvania; Medical College of PA.

	CURRENT FY 1982	LAST FY 1981
BED CAPACITY	<u>478</u>	<u>482</u>
OPERATING BEDS	<u>421</u>	<u>429</u>
AVERAGE DAILY		
INPATIENT CENSUS	<u>334</u>	<u>366</u>
OUTPATIENT VISIT (ACCUM.)	<u>52,094</u>	<u>169,459</u>
WAITING LIST:		
SERVICE-CONNECTED	<u>0</u>	<u>0</u>
NONSERVICE-CONNECTED	<u>0</u>	<u>0</u>

EXPLAIN THE REASON FOR THE WAITING LIST:

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR	<u>25,296</u>
NUMBER OF APPLICATIONS ACCEPTED	<u>25,043</u>
NUMBER OF APPLICATIONS REJECTED	<u>809</u>
APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR	<u>8,135 (1/31/82)</u>
NUMBER OF APPLICATIONS ACCEPTED	<u>7,964 (1/31/82)</u>
NUMBER OF APPLICATIONS REJECTED	<u>171 (1/31/82)</u>

BEST COPY AVAILABLE

STAFF

TOTAL MEDICAL CENTER PERSONNEL (FTE) 1398.3
 CORE RATIO 1.68
 STAFF PHYSICIANS (FTE) 102.3
 CONSULTANTS ON THE ROLLS 124
 ATTENDING ON THE ROLLS 26
 RESIDENTS 113 +3 Dental
 MEDICAL STUDENTS from 96 to 105 per month
 PHYSICIAN EXTENDERS 2 Physician Assistants

MAJOR PERSONNEL SHORTAGES

PHYSICIANS (FT BY SPECIALTY) Radiology; Anesthesiology
 REGISTERED NURSES 19 (2/19/82)
 LICENSED PRACTICAL NURSES 12
 NURSING ASSISTANTS +2
 OTHERS _____

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED) 3 (2/17/82)

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED) 4 (2/17/82)

SUMMARIES PENDING 28 (2/17/82)

TOTAL NUMBER OF REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS
 (2307) ON HAND WHICH HAVE NOT BEEN COMPLETED AND RETURNED TO VA
 REGIONAL OFFICE 383 (2/17/82)

OPERATING BEDS IN NURSING HOME CARE UNITS 0

FUNDS

AVERAGE COST PER PATIENT DAY \$ 237.83

AVERAGE COST PER OUTPATIENT VISIT \$ 30.22

AVERAGE COST PER NHCU DAY 0

AVERAGE COST PER PATIENT DAY IN COMMUNITY NURSING HOMES 44.68

MEDICAL CENTER BUDGET ALLOCATION (THIS FISCAL YEAR) 57,110,651.00

MEDICAL CENTER BUDGET ALLOCATION (LAST FISCAL YEAR) 56,032,952.00

BEST COPY AVAILABLE
 BEST COPY AVAILABLE

VETERANS ADMINISTRATION OUTPATIENT CLINIC VISIT STATISTICAL REPORTLOCATION Broad & Cherry StreetsDATE OF INFORMATION February 22, 1982CLINIC DIRECTOR BARRY L. BELLCHIEF OF STAFF GEORGE E. MC NEAL, JR., M.D.

<u>STAFF</u>		<u>PHYSICIANS (FTE BY SPECIALTY)</u>	
TOTAL OUTPATIENT CLINIC PERSONNEL (FTE) <u>170-180</u>		<u>* (Over)</u>	
OFFICE OF DIRECTOR <u>1</u>		REGISTERED NURSES <u>9</u>	
MEDICAL PERSONNEL - DENTAL <u>JEFFERSON-Coates</u>		LICENSED PRACTICAL NURSES <u>0</u>	
FULL-TIME <u>18 3 1</u>		NURSING ASSISTANTS <u>2</u>	
PART-TIME <u>25 9</u>		<u>*OTHERS</u>	
*ADMINISTRATIVE PERSONNEL <u>MAS=67</u>			
(* = BREAKDOWN OF POSITIONS)			

FISCAL YEAR STAFF VISITS
CUMULATIVE TO DATE 27,283

SAME PERIOD
PRECEDING YEAR 33,359

FISCAL YEAR FEE BASIS VISITS
CUMULATIVE TO DATE 17,968

SAME PERIOD
PRECEDING YEAR 21,517

VA FORM 10-10 APPLICATIONS FOR MEDICAL TREATMENT
RECEIVED LAST FISCAL YEAR 331
NUMBER OF APPLICATIONS ACCEPTED 326
NUMBER OF APPLICATIONS REJECTED 11

VA FORM 10-10 APPLICATIONS FOR MEDICAL TREATMENT
RECEIVED THIS FISCAL YEAR TO DATE 361
NUMBER OF APPLICATIONS ACCEPTED 353
NUMBER OF APPLICATIONS REJECTED 8

REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507)
RECEIVED DURING PREVIOUS MONTH 456
DISPOSED OF DURING PREVIOUS MONTH 408
PENDING END OF PREVIOUS MONTH 436

FUNDS

AVERAGE COST PER OUTPATIENT VISIT \$30.22
OUTPATIENT CLINIC BUDGET ALLOCATION \$2,535,295.00 (Plan-82)
(THIS FISCAL YEAR)
OUTPATIENT CLINIC BUDGET ALLOCATION \$2,367,927.00 (Actual-81)
(LAST FISCAL YEAR)

BEST COPY AVAILABLE

Dental - 3 FTE

Psychiatry (Philadelphia) - 12.4

Psychiatry (Coatesville/Jefferson) - 4.5 FTE

Surgery - .5 FTE (Dr. Lockhart, Optometrist)

Neurology - 2 FTE

Podiatry - 2 FTE

Administrative Medicine

General Medicine - 3.3 FTE

Agent Orange - 1 FTE

Orthopedics - 1 FTE

Medical Service

General Medicine - 2 FTE

Geriatrics - .2 FTE

Hypertension - .4 FTE

Cardiology - .1 FTE (Dr. Goodman, COS Office)

EXCERPTS FROM HUD/INDEPENDENT AGENCIES SUBCOMMITTEE HEARING—MARCH 9, 1982

Mr. BOLAND. The next line of questions concerns the Minneapolis Hospital and I would like to ask Mr. Sabo to handle that.

Mr. SABO. Thank you. Mr. Chairman. Welcome to the committee, Mr. Nimmo.

Mr. NIMMO. Thank you.

Mr. SABO. Before I raise these questions, let me indicate my appreciation to the VA for working out the problem at the data processing center at Fort Snelling. My understanding is there is a new computer and the people are working hard and I think your will continue to find those people productive and hard workers in the years ahead. Hopefully they will collect more bills than expected.

In looking at the 1983 request, construction funds for Minneapolis are not included. We provided 15 million in the 1981 appropriation for planning. The future estimate of costs at that time was \$206.4 million. We expected those construction funds to be requested in 1983 and they were not.

Why are the funds not in the 1983 budget?

Mr. NIMMO. The answer there, I think Mr. Sabo, is that we were not that far along in the planning. I would ask Bill Salmond to address that.

Mr. SALMOND. That is correct, Mr. Nimmo. We entered into a contract with the architect out there in June of 1981 and we really have not completed the final preliminaries until just recently, and our construction schedule is such that we would not be able to handle the money in 1983.

Mr. SABO. When do you expect the plans to be finalized?

Mr. SALMOND. The working drawings?

Mr. SABO. Yes.

Mr. SALMOND. In October.

Mr. SABO. October of?

Mr. SALMOND. 1983.

Mr. SABO. Okay.

Mr. NIMMO. Let me say with respect to Minneapolis, Mr. Sabo, that is one of the projects under review. We know we have to have a hospital there. We know we have to do something about the existing facility and we are moving as rapidly as possible to revalidate that one, to be among the first to be revalidated, but it is undetermined at the moment whether it is to be a new hospital, and the scale of the hospital, or whether a major renovation project of the existing hospital would be in order.

Mr. SABO. That was studied once before?

Mr. NIMMO. Yes, it has been studied.

Mr. SABO. These working drawings—if they are ready in October 1983—would be ready for moving on?

Mr. SALMOND. Yes.

Mr. SABO. According to the information provided last year, the award date for Minneapolis was August 1, 1981. Part I was to be awarded March 1, 1982, and the remaining phase was scheduled over the next few years. I believe that is correct for the past analysis.

What time frame of construction funding were those dates predicted on?

Mr. SALMOND. That was broken down into several phases and we received the money in 1982 for—

Mr. SABO. In the 1981 appropriation.

Mr. SALMOND. Yes, for the design. We did have it broken down into a number of phases. It probably still should be done in phases.

However, we are now involved in revalidating the project and it probably would be wiser to go with the whole project at once.

Mr. SABO. If you got funding in this bill, could construction begin?

Mr. SALMOND. In 1983?

Mr. SABO. Yes.

Mr. SALMOND. It could be worked out, yes, sir. If we did it in phases, yes.

Mr. BOLAND. Let me ask a question. Were you told to split the planning on this particular hospital?

Mr. SALMOND. No, sir.

Mr. BOLAND. You were not?

Mr. SABO. I still want to know why funding is not in this request. It seems to be well along the way in terms of being ready.

Mr. NIMMO. Well, Mr. Sabo, in that 5-year plan were \$5.7 billion in construction projects. It just did not appear to me in the preparation of this budget that we could

sustain in the economic environment in which we find ourselves the rate of construction that that plan contemplated.

Moreover, it seemed to me that in a number of these projects, there were serious doubts about whether or not they were properly planned. The Minneapolis project, for example, on the basis of numbers of beds or square footage, whatever you want to use, was the most expensive hospital ever designed by the Veterans' Administration. It seemed to me that perhaps we ought to take a second look at that and be sure that that was really the kind of project that was justified for that locality. That was one reason that it was scheduled for reexamination and revalidation.

Mr. SABO. I am in the unique position of having raised those questions in 1981, I was told I was dead wrong by the VA Administration by the authorizing committee.

Mr. NIMMO. Had I been here in 1981, I might have agreed with you, Mr. Sabo.

Mr. SABO. You know that sort of complicates things because we raised questions at that point.

Mr. NIMMO. I appreciate that.

Mr. SABO. And we were emphatically told that the questions we raised were wrong and we should proceed on the basis of original plans.

Mr. NIMMO. We know, as I say, that—

Mr. SABO. I guess at times I accept defeat and I think we should move on with this project.

Mr. NIMMO. I would not want to express it that way. I asked Chuck Hagel to go up there and take a look at that hospital which he did just recently and he came back and said we have to do something. We have to have either a new replacement hospital or we have to do major renovation of the one we have, so we need to take a look at it and look at it quickly and make a decision. That is what we plan to do.

Mr. SABO. If you are given construction funding for Minneapolis in 1983 will you begin construction?

Mr. NIMMO. Well, I am not sure we could. My understanding has been that we were not that far along in the planning process.

Mr. SABO. It sounds like working drawings would be ready to go.

Mr. SALMOND. We could get involved in some demolition work. Utilities, that sort of thing. But your foundation work could not begin until October of 1983.

Mr. SABO. Okay.

I am curious as relates to the working drawings for Albuquerque, when will they be ready? We did not appropriate the planning funds until 1982, a year later than Minneapolis.

Mr. SALMOND. We expect a construction award in July of 1983.

Mr. SABO. When will their working drawings be completed?

Mr. SALMOND. Approximately 3 or 4 months prior to that date.

Mr. SABO. So the working drawings in Minneapolis will not be finished until October 1983?

Mr. SALMOND. Yes.

Mr. SABO. But Albuquerque, which got funding a year later, will be finished in July of 1983?

Mr. SALMOND. Yes.

Mr. SABO. Why the difference?

Mr. SALMOND. We started the preliminary plans sooner in Albuquerque than we did in Minneapolis. By almost a year in fact.

Mr. SABO. Before you received the direct planning funds?

Mr. SALMOND. Yes, sir. We can do that with advance planning funds and that process.

Mr. SABO. The first 5-year medical facility construction plan dated August 1979 ranked Minneapolis number 2 on the list of 10 hospitals most in need of construction, replacement or alteration.

In the October 2, 1979 letter from Max Cleland which was a revised list of 10 hospitals, Minneapolis was listed as number 1. The project was rated 1 in 1980 and 1981 submissions.

So it has consistently been number 1 on the list of hospitals most in need of construction or replacement or alteration.

I believe that is correct, is it not?

Mr. NIMMO. Well, it may well be, Mr. Sabo. That was part of my problem. I could not, in trying to find why they were listed in any particular sequence, find any kind of statistical or demographic basis for saying that, yes, we need a hospital here, more than here, for these reasons.

Mr. BOLAND. But this is a replacement hospital. This is one of the oldest hospitals in the VA system. I understand it was built in 1928. Is that correct, Bill?

Mr. SALMOND. Yes, the original.

Mr. BOLAND. So you have been looking at this thing for some time now. You know this is one in the 5-year plan, and the questions that Mr. Sabo propounded with respect to the phases here was August 1 of 1981, that was the first phase. That figure is correct, is it not?

The first phase was to be completed on August 1 of 1981.

Mr. SALMOND. The first phase completed?

Mr. BOLAND. The award.

Mr. SALMOND. The award, yes.

Mr. BOLAND. Was to be made, August of 1981.

Mr. SALMOND. That would probably be for temporary building.

Mr. BOLAND. For what?

Mr. SALMOND. Temporary building so you could demolish existing structures.

Mr. BOLAND. What about Phase II, the construction award date is March 1 of 1982.

Mr. SALMOND. That would have been demolition.

Mr. BOLAND. Is the bottom line, Mr. Administrator, that this is a very expensive hospital targeted at about \$204 million and Houston probably around \$400 million, is it because they were so expensive you want to knock them out of starting construction this year? Is that really the point?

Mr. NIMMO. I would not say that is correct. I think because they are tremendously expensive that we need to be absolutely certain that we are building the proper facility in the proper place, the proper kind of facility. So that is why I have asked that they be revalidated before—

Mr. BOLAND. What does revalidation mean? That is kind of a buzz word. What does that mean?

Mr. NIMMO. It means that I have formed a task force composed of the Deputy, Mr. Sullivan, a member from the Department of Medicine and Surgery, from the Office of Construction, from the Office of Procurement and Supply to examine quickly the entire file on each of these facilities.

We want to be looking at it in terms of what we know about the demographics. Then if there is any question about that facility, to make an on-site examination, go down and take a look at it. If there is still a question, then we will have an in-depth examination on-site of the facility.

Mr. SABO. I am curious how this all fits in with the working drawings that are continuing.

Mr. NIMMO. Well, it is something that poses a dilemma for me because we have been going for some time obviously on Minneapolis as we have in other places, preparation of working drawings and so on, and if we stop that, then, of course, we put ourselves way behind.

On the other hand, the cost of those working drawings in relation to the cost of the entire project is not very much. So that is the reason on major projects such as Minneapolis that we are moving just as rapidly as we possibly can to come to a decision, yes, it is go with the project as planned; or no, we have to make some changes.

We want to do that just as quickly as we can. But in the meantime it seems to me that we start out with the assumption basically that the project is probably right and so it is appropriate to go on with the planning.

Mr. SABO. You know you raised several issues. One is a question of rehab rather than replacement.

Mr. NIMMO. Yes.

Mr. SABO. And the VA did an extensive study on, and their conclusion was that in the long term costs it would be cheaper to replace than rehab. You know, I am not sure that I am making such a particularly good judgment on that, but there seems to be broad consensus that replacement was needed, that it made more sense than rehab.

If you want to go back through the whole thing, it moves us back I do not know how many years.

Mr. BOLAND. Back to square one.

Mr. SABO. Yes. And the architects were hired, did their studies, they looked at the alternative of replacement or rehab and the conclusion was, I assume of central VA, that replacement is what made sense.

Mr. NIMMO. I guess I could only say, Mr. Sabo, that you know unless there is more than has been presented to me I cannot find convincing material to attest to that assertion.

Mr. SABO. I am not sure what has happened to all the old studies. I assume they are still available. They were rather detailed architectural studies, am I not right?

Mr. SALMOND. You are right.

Mr. SABO. On the question of replacement or rehab, and that predates the time I was in Congress and the decision was made. Am I not right that replacement was the decision made?

Mr. SALMOND. At that time, yes, sir.

Mr. NIMMO. Let me assure you I am not trying to play any kind of games with Minneapolis or any other hospital. I just want to be sure, convinced that when we spend \$280 million there we are spending it for something for what we need and in that location.

We know we have to have something better in Minneapolis than what we have. I just want to, before I approve the contract for that amount of money I just have to be convinced in my mind that we are doing the right thing. I have not been able to find the evidence thus far to give me that assurance.

Mr. SABO. I assume the architectural studies were conducted, when were they made? When was that study done?

Mr. SALMOND. 1980.

Mr. SABO. Those are still available?

Mr. SALMOND. Oh, yes. I would assume that they are available done by two reputable people.

Mr. NIMMO. We certainly will in our revalidation process go through these very carefully.

Mr. TRAXLER. What troubles me about this, sir, is that this chairman and this subcommittee have striven mightily to keep the VA hospital—and Mr. Boland really deserves credit for this and he does it sometimes over my no vote, to keep the VA hospital construction program, to the highest extent possible, free from politicization, and that frequently puts him at odds with members of the House, and occasionally with the Senate, and we have relied, you know, with quoting the VA itself on what is necessary and relying upon the priorities developed within the VA for hospital replacement or renewal, and the difficulty we now find ourselves in, that there is a suspicion that perhaps the VA itself can no longer be trusted in terms of its priority listings, and the faith that we have been able to establish both within the subcommittee and with our colleagues in the Congress, in the Senate, perhaps is going to be misplaced.

And, if, indeed, the Administration itself does this, how can we then keep our construction budget free from the whims of 435 members of the House, and 100 members of the Senate?

Mr. NIMMO. Our objective in this whole matter, Mr. Traxler, is to develop objective demographic statistical criteria upon which to establish our priorities.

We know, you know, I know, and we all know that these things were never totally removed from the political arena, but the Veterans Administration has an absolute responsibility to develop the objective and defensible criteria in which we can come to you and say, "We think these are where the facilities ought to be built to support the veteran population in that locality."

I cannot do that today or come to you and show you the criteria on which this program was based.

Mr. TRAXLER. There were some projects you scratched and some you did not. Which ones are going to go forward?

Mr. NIMMO. One is Albuquerque.

Mr. TRAXLER. Others?

Mr. HAGEL. We have not scratched any project, Mr. Traxler. There has been no project withdrawn.

Mr. TRAXLER. You are not requesting funding for construction. Can you tell us your view, what is the term used?

Mr. NIMMO. Revalidation.

Mr. TRAXLER. You are revalidating, which means that the project as it has been conceived over the years, and the work that has been done in terms of validating the need for a new facility and as the planning goes forward, you are saying really that that may not be the ultimate decision, or you may make a decision to do a renovation job.

I guess my problem with some of this, at a point in time, we have to say enough is enough, and in the case of Minneapolis, where literally years of planning and validation had gone into the decision, I am troubled by the priority listings system and what all of this means for the future. Is it a system that changes with one Administration to the next Administration?

Is it one which will change from Administrator to Administrator? What position does this leave the members of this committee in when we are attempting to give the highest rationalization for the construction program when we are told that the

listing and the priorities that have been established may not be proper and that they have to be revalidated?

We don't know how periodically as yet. Probably the future will tell us that. We come away with the feeling that this project, the Minneapolis one, fell victim to budget considerations, as opposed to the criteria that goes into your putting a project on the go or no-go list.

Mr. NIMMO. The advice I had at the time of the budget preparation, Mr. Traxler, was that we were not that far along with the planning of Minneapolis. That seems to have changed somewhere between then and now.

Let me say once again, I as much as you want the Veterans Administration to be able to say with absolute conviction and be able to show you the statistical demographic objective basis on which we make these selections.

I cannot do that today, and because of that, I want to take a second look at these projects that are tremendously expensive and getting more expensive every day, as you know.

Mr. BOLAND. They all are. Not only VA hospitals, but all the hospitals are tremendously more expensive.

Mr. SABO. Our process was we asked the VA to make the request through the local Health Board who did take a look and made recommendations that frankly were for a smaller hospital. They looked at the demographics, and I am not sure there was any quarrel over the demographics, but there was some disagreement on the usage which is a different question. All that data is currently available and has been available to the VA, those types of questions have been raised for, I suppose, a year and a half now.

Materials for reexamination have been available for a long period of time, and it gets to be sort of an untenable position to say this planning process goes on. I happen to be a proplanner. I believe one needs to take critical looks at specific actions, but I also get impatient with a process that doesn't end. When it relates to a particular project, at some point a conclusion has to be reached.

I have got a highway in my district that they have been planning for 20 years. When I am long gone from here, the planning process may end, but now the vacant land sits. That is sort of a failure of the process, even when some of the questions raised are legitimate questions.

Mr. HAGEL. May I address very briefly Mr. Sabo's and Mr. Traxler's questions?

One of the most unique parts of this that has been discussed at all this morning is the initiative that Dr. Custis began two years ago, what he refers to as medical district initiating program planning, and it speaks very directly to your questions and concerns about, is this a merry-go-round we are on?

Do we see every four or two years a change in the criteria we used? It would be helpful, Mr. Chairman, if Dr. Curtis could explain why he came to the conclusions he did two years ago in what he initiated and what we feel will be very helpful.

Mr. TRAXLER. Relate it to the Minneapolis hospital.

Dr. CURTIS. You asked too much.

Mr. TRAXLER. I thought there was an interruption in the game here, that we wanted to make sure that your answer and the question related to the issue at hand.

If it does not, we are going to have some questions for you on medics later. If it does not relate to the issue at hand, we don't want to talk about it now.

Mr. NIMMO. We expect to have Minneapolis in the 1984 budget.

Mr. TRAXLER. Oh, that is nice.

Mr. NIMMO. But I don't know whether it is going to be, you know, have the same amount of square feet in it that the present plan calls for, and it conceivably could be a major renovation project, but we are going to move, as I said before, Mr. Sabo, very quickly to reexamine all of that pile of data we have got and come to a decision, but there will be no delay.

Mr. SABO. My concern is, I think all the data is there and has been there for a long time, both the renovation versus the replacement issue, and the question of the appropriate size. It has been there for two years or more.

Mr. NIMMO. We are going to go through it in great detail and very quickly.

Mr. BOLAND. Let me just ask, was the Minneapolis hospital one of those that was requested in the 1983 budget of OMB for construction?

Mr. SALMOND. No, sir.

Mr. BOLAND. It was not.

All right, let me ask you, Bill, whether or not the Minneapolis working drawings are on schedule for phases I and II for the dates that you gave us last year, the August 1st date and also the March date on the working drawings.

Mr. SALMOND. I don't think I could answer that right now.

Mr. BOLAND. Well, you indicated that the working drawings would be, that the award would be made on those particular dates. That was the information you gave us last year, and so we would like to know if the working drawings are not on schedule, that is, by the dates you gave us, you may supply for the record, if they were not on schedule, why weren't they on schedule?

Go ahead, would you like another question on it?

Mr. TRAXLER. We can't let this go. When are you going to complete the revalidation process?

Mr. NIMMO. Well, it will be ongoing until we get through all of that five-year construction plan.

We are going first to those projects that were originally scheduled for 1983 and some slipped to 1984, and those are the ones we want to get to first, and get them in the 1984 budget if we can.

Mr. HAGEL. There are approximately 50 projects.

Mr. TRAXLER. This ought to be at the top of the list of those 50, since it has been consistently at the top of the list.

Mr. BOLAND. It was at the top last year and the year before.

Mr. TRAXLER. Why do we have to wait for an answer from you until next year's budget hearings to see what you want to do in 1984? Why don't you advise us at the earliest opportunity as to what your decision might be so that this committee may consider it in the event it can receive funding in the 1983 budget, if the committee were to decide that.

Can we ask you that?

Mr. NIMMO. I think I can do that.

Mr. TRAXLER. Good.

STATEMENT OF GORDON H. MANSFIELD, ASSOCIATE LEGISLATIVE DIRECTOR,
PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Subcommittee, it is a privilege for me to appear today on behalf of the members of Paralyzed Veterans of America. I sincerely appreciate the opportunity to express PVA's concerns regarding construction plans for Veterans Administration health care facilities.

At the very outset I would like to state PVA's most sincere feelings about veterans health care: meeting the health care needs of the individual veterans who have served in the nation's Armed Forces is a national responsibility and is a duty which the federal government must not forsake.

It is widely recognized that military preparedness is a price America must pay for its independence. In private enterprise there is a phrase, "the cost of doing business," which describes the expenses a given concern must pay for its continued operations. PVA firmly insists that caring adequately for citizens who render valuable service in defense and protection of the nation is equally the nation's cost of doing business.

The above constitutes PVA's most fundamental premise with which we approach all discussions of veterans health care.

Mr. Chairman and Members of the Subcommittee, PVA is grateful for your dedication to the well-being of the nation's veterans. A year ago, on March 11, 1981, PVA testified before this Subcommittee concerning the VA's medical construction plans, and we discussed a March 4, 1981, New York Times article which pointed out the Reagan Administration's proposed cuts in the VA's fiscal year 1982 budget. The article included some of the Administration's long-term goals which would affect the VA health care system. Some of these goals, such as halting construction of the Camden, New Jersey, and Baltimore, Maryland, VA medical centers, have been realized by the Administration.

On March 2, 1982, PVA presented to the full House Committee on Veterans' Affairs our Annual Statement of Legislative Concerns. It was noted during that presentation that the Administration's fiscal year 1982 VA budget had sought to curtail all areas of VA health care funding. However, the Administration's fiscal year 1983 VA budget request, as released on February 8, 1982, provided more equitably for veterans health and medical services as extended through the Veterans Administration.

PVA recognizes that the increased funding recommendation which was made by the Administration for fiscal year 1983 came largely because of the diligence of the Members of this Subcommittee and of the Members of the full Committee on Veterans' Affairs. On behalf of the members of PVA, I would like to express our appreciation for your efforts.

We are grateful not only for your efforts but we also appreciate the reasonable, non-partisan approach that this Subcommittee has consistently taken for ensuring that veterans health and medical needs are met.

PVA shares what must be frustration on the part of the Members of this Subcommittee as you have reviewed the VA's projected long-term construction plans over the years. We have seen those long-term plans rendered virtually meaningless when there have been budget recommendations and readjustments resulting in inadequate construction funds; when there has been an Administration goal to enroll veterans in non-VA health care systems; and now, when there is to be a freeze on construction pending further examination of the need for VA hospitals.

During presentation of PVA's Annual Legislative Statement we expressed our deep disapproval with some of the Administration's recent actions: we reiterate them at this time, in a request that this Subcommittee closely monitor the Administration's review of VA hospital construction.

In that earlier statement we mentioned that the Administration was guilty of obscuring its true intent when it released on February 8, 1982, its fiscal year 1983 VA budget request because then, on February 19, it placed a freeze on VA hospital construction projects during fiscal year 1984 and subsequent years. This was done by means of the formation of FPACC, the Facility Planning and Construction Committee, and by its demographic review of the veteran population and VA construction criteria.

PVA was reminded of the Baltimore, Maryland, VA medical facility where \$8 million had been spent for planning, only for the Administration to then cancel the project. In short, PVA sees the announcement of February 19, to be an adjustment to the budget as revealed on February 8, because a single construction project can extend through several consecutive budget years.

PVA has examined a draft of the VA's "General Methodology Manual for Needs Assessment Studies," which is dated January 29, 1982, and which was released to PVA on March 19, 1982. This Manual is to serve as the basis for the demographic study announced by Administrator Nimmo. PVA is having an independent demographics specialist review the methodology to be used by the VA, in order to form a better assessment of the VA's approach. That review should be available within a few days.

PVA stated its postulate earlier, that we seek adequate care for the nation's veterans. The VA likewise states its basic premise at the outset of the Methodology Manual for Needs Assessment Studies, and some of the opening comments in the VA's Manual which cause PVA great concern are as follows:

"These reports, will diverge from the traditional studies in that the following issues will be addressed: resource costs, placement criteria, sharing arrangements, and *alternative ways of providing the health care service.*" (Page 1, emphasis added)

"Sharing with other health care providers will be maximized. We anticipate changes in the law which will allow much broader sharing than we have had in the past." (Page 2, emphasis added)

"After statutory requirements are met, priority attention will be accorded to planning for: the aging veteran population, rehabilitation and ambulatory care." (Page 2, emphasis added)

These points, which are taken from the VA's Manual, are not lifted out of context—rather, the VA has emphasized them as bases for its examination of the VA's construction of medical facilities.

One could interpret the VA's efforts to mean, based upon these premises and a lack of clarity in its statement, that there will be a greater reliance on non-VA resources for veterans health and medical services. It is also probable that the needs of older veterans are to be relegated to subordinate priorities, even though non-VA medical resources such as Medicare and Medicaid are being diminished. Finally, the VA anticipates that Congress will agree to these and other changes.

PVA has opposed the Office of Management and Budget's senseless effort (through Circular A-76) to force the VA to use private contractors even though it has already been established that the VA provides cost-effective care for the nation's veterans. It must be emphasized that PVA is in complete agreement with existing law whereby the Administrator of Veterans Affairs is to use contract services whenever and wherever it is determined that such services are needed for veterans health and medical care. This is a very satisfactory system whereby the Administrator gets to weigh the VA's capabilities, its available funding, and the requirements placed on the VA's facilities, personnel, and medical equipment: then he can determine the best possible combination to resolve any short-term and/or long-term problems faced by the VA health and medical system. It is far from clear just how the provisions of Circular A-76 are to improve resource allocation, but it is clear that it

is designed to reduce the size of the federal work force and to reward private operators with federal contracts.

We have also (during this Subcommittee's investigation of VA construction last year) warned that non-VA medical care providers have built excessive beds and now want the VA health care system abolished so that they can benefit from the expanded clientele. A year ago we stated: "PVA asks supporters of such a system to examine closely other government contract programs which have created too many cases of physicians' overcharging the government or charging the government to the upper limits of the existing reimbursement allowances." We repeat this request at this time, because we seek for veterans health care to be not only adequate but to also be fiscally responsible.

That earlier challenge was made to those who sought to abolish the VA health care system by means of "Enrollment": veterans would have been excluded from VA services and forced to receive care in private systems. It is somewhat difficult for PVA, at this time, to distinguish between the premises underlying "Enrollment," OMB Circular A-76, and the VA's current efforts at "Needs Assessment Studies."

PVA is conscious of the need for responsible placement of VA hospital construction projects: on past occasions we have supported demographic studies of the veteran population which utilizes VA health and medical resources, as one way of ascertaining more clearly where VA facilities are needed. We remain dedicated to such a study, providing it is used in an honest effort to upgrade and improve the VA health care system and the services it offers to the nation's veterans.

We recognize that such a study, as designed recently by the VA, can have one of three effects: first, the most adverse would be for the study to be used as an excuse for and method of abolishing the VA health care system. However, such a radical move is not anticipated and we foresee that a more subtle destruction could arise out of the VA's new analysis of the VA system.

This more subtle but quite harmful use, our second of three observations, is based on the knowledge that the study could be merely an effort at foot-dragging, thereby allowing the VA system to erode. This use of the study would be in keeping with the trend which has been developing for several years, and evidence of this has been the drop from 96,400 VA operating beds in 1972 to a projected level of 80,400 in 1983. PVA feels that only part of this reduction has come because of the VA's growing emphasis on outpatient care. Rather, the system has been allowed to gradually degenerate, even though the VA has done almost endless studies on ways to improve the system.

One good example of the way this decline has made itself apparent is that the VA has studied expanded outpatient care and concluded that it should replace the emphasis on inpatient care. We agree with the VA that this change in emphasis has been cost effective. At the same time the VA has studied the aging veteran population and concluded that "something" must be done to meet their needs. There has never been a clear-cut answer as to what that "something" is to be; however, we have watched beds being taken out of the VA system when they could be used, in many instances, to provide long-term care facilities. The VA has stated on many occasions that it needs such long-term care facilities if it is to care for the ever-growing number of aging veterans. Yet, the VA has followed through on its studies and abolished VA hospital beds, but it has not followed through on its studies which reveal that long-term beds are needed. Here we see examples of the way the VA has used its studies in the past to reduce the number of VA hospital beds and at the same time has not used its studies to solve a problem which could be partially resolved by maintaining those beds, but by using them for different types of health care for veterans.

As we all know, studying a federal program can be used to destroy it, if the study is meant only as a stalling tactic. (We fear some of this negative use of the study by this Administration based upon its willingness to fund studies for OMB Circular A-76 implementation while ignoring the funding needs of essential programs such as the scholarship fund designed to recruit VA nurses.) This use of delaying tactics was revealed last year when the Administration was content to allow the VA to proceed well into the new fiscal year without an appropriations, making it necessary for the agency to struggle along at generally existing, lower levels of operations until inflation had taken its toll and the VA had once again been eroded. With all this in mind, we know that the study can be one more subtle effort to weaken an already anemic agency which was intended to serve the nation's veterans.

Our third observation of the purpose to which the study can be applied is an optimistic one. The demographic study can be a sincere effort to place VA health and medical facilities where they are most needed, not to curtail VA construction and

not to re-define veteran eligibility so as to make fewer veterans capable of using VA health-care services.

We remain dedicated to long-term planning for improved VA resource allocation, and we have asked a number of times that there be established a Presidential Commission for this purpose. It was somewhat reassuring, therefore, when the VA presented on March 19, 1982, its "Discussion Paper on Veterans Service Organizations Involvement in FPACC." "Recognizing that the veterans service organizations represent the users of the VA health care system," the Discussion paper states, "the Administration has directed that the Facility Planning and Construction Committee (FPACC) establish liaison with representatives of the service organizations."

PVA is pleased that users' views are to be part of the Committee's investigation, and we are completely dedicated to reasonable cooperation with the Administrator, so long as we agree on our mutual objective. PVA enters the review of VA medical construction in good faith, if the review is the approach determined by the Administration and Congress to make available improved services for veterans.

Maintaining an adequate, separate health care system for veterans is PVA's highest goal: we have listed above some of the VA's premises which we fear threaten the integrity and viability of that system. And, we are especially dependent on this Subcommittee to ensure that the VA's review of its medical facility construction plan does not become a perversion which undermines the nation's system of providing cost-effectively for the needs of those who have served in the Armed Forces.

Mr. Chairman, this concludes my statement and I will be glad to answer any questions that I can.

STATEMENT OF ROBERT E. LYNCH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, the American Legion appreciates the opportunity to present its views at this time on the Veterans Administration medical construction program. May we say that we believe the Subcommittee's consideration of this matter is most timely in view of the Administrator's initiative, announced first to the press on February 19. The news release of that date was the first information our organization had of this matter, and it is our understanding it was also the first intimation to the Committee on Veterans Affairs that the Administrator was calling into question the validity of the renovation and replacement program developed by the Department of Medicine and Surgery.

At the outset, and before we discuss the details of the Administrator's initiative, as we understand it, let us first say, for The American Legion that this organization has always supported the concept of tight, cost-effective management by the Veterans Administration. At no time since the VA was established have we ever sanctioned the idea of loose, irresponsible management of the agency. Where we have seen problems of management develop we have suggested and supported improvements in management techniques. In our submission to the transition team at the time of inauguration of the present Administration, we suggested a manpower study of VA, to determine whether its personnel management was as good as it should be and whether it was cost-effective. Therefore, we have no problem with any suggestion, or initiative to examine into and refine the management techniques employed by the Presidentially appointed managers, or any examination of the medical construction program to insure its validity with reference to the needs of the VA's health care delivery system.

Having said that, however, we must add that the method chosen by the Administrator to launch this initiative, and the comment attributed to him at that time, as well as other statements recently made by and attributed to him, raise in our minds the question of whether this Administrator does in fact understand the Congressionally mandated mission of VA to provide health care to sick and disabled veterans, to participate in the training of health manpower for the nation, and to engage in basic research that will advance the state of medical science for the benefit of the entire American people. Nothing has happened to change that Congressional mandate, and in fact, recent Congressional action has broadened the VA's health care mission by making it the principal contingency back-up to the medical care program of the Defense Department, so that it now has a fourfold mission.

Before we discuss the details of the Administrator's initiative as we understand them to this point, let us, if we may, posit a few absolutes that govern this entire subject.

First, the nation has a fundamental obligation to care for the service disabled. Second, the mandate to provide care for the nonservice-connected was first set forth

in the World War Veterans Act of 1924, and was intended to insure that veterans who might be suffering from service induced disabilities, whether or not they were clearly identifiable would not be denied care, and that veterans who were poor would not be neglected, in consideration of their contribution to the nation's security. A further consideration of this broadened mandate was the fact that in order to assure a quality of care for the service disabled, a mix of patients would have to be provided that would enable the Government to maintain a comprehensive medical care program. All of these mandates have been largely met during the years since passage of the World War Veterans Act. The American Legion is aware of no sentiment among the American people that the mandates should be changed.

Now, we move, if we may to the Administrator's statement to the press of February 19, in which he first revealed his initiative. In that statement Mr. Nimmo said: "We must clearly identify our changing health care needs. We must then firmly establish our health care priorities, justify them, plan for them, build for them and if necessary change them." Mr. Nimmo further commented: "Until the Agency can justify its construction program, I believe it would be irresponsible to proceed with a major program for fiscal year 1984 and the outyears." Our immediate reaction to these statements is that it is not what Mr. Nimmo said that we challenge, but what his statements imply. The implication is that VA procedures heretofore have not justified the medical construction program. The American Legion rejects that implication.

The 172 hospitals and 225 clinics of the present VA system represent a multi-billion dollar capital investment in the most comprehensive health care delivery plant to be found in the nation, and perhaps in the world today. The fact is that plant is in a deteriorating condition. It includes hospitals built before World War II. It uses buildings some of which were constructed before the turn of the century. Many other of the present structures were built immediately following World War II. Many of them are more than 30 years old. The changes in medical science and technology during these years have been massive. These older hospitals are simply not configured to adapt to modern medical technology. Just as one example, in the 1940's and 1950's there were no such things as intensive care units, there were no dialysis units, the requirements of surgical suites were entirely different than they are now; there are entirely new standards of privacy and space allotments, now mandated by the Joint Commission on the Accreditation of Hospitals. All of these things have set up basic changes that must be made to enable doctors to practice modern medicine within the VA system.

Beyond that, our Field Representatives visit about 65 VA hospitals each year. Their site visit reports indicate repeatedly, shortage of space to accommodate enlarged staffs—required again by the practice of modern medicine—and cramped spaces for expanding clinics, and the need for ever more square footage for storage space for medical supplies and equipment, and the need for libraries and education facilities. All of these things are essential to the system. In most cases they are not affected by the demographics of the veteran population.

And, having mentioned demographics, let us say a word about that subject. The VA medical care system was first built to accommodate a veteran population of 4 million—the veterans of World War I. Following World War II, it was expanded to care for a population enlarged by 14 million. And since that time there have been added 5.5 million Korean veterans, and now an additional 9.5 million veterans of the Vietnam Era. The result is there are veterans in every part and parcel of this nation. The fact that they are on the move, in a mobile population has not changed that fact. It is certainly true that the Sun Belt states are acquiring ever larger veteran populations, and that VA will have to make adjustments for that fact. But it is also true there will be large numbers of veterans in every part of the country for the foreseeable future. We have no objection to continuing demographic studies of the veteran population. We will support needed changes in the configuration of the system that are clearly demonstrated. We reject the implication that the present demographic configuration of the veteran population calls for any move to close any of the hospitals now operating.

It is also true that the rate of usage in some of these hospitals fluctuates. We believe this is due to a combination of factors, including the recent emphasis on outpatient care to reduce the inpatient load. But the WW II veteran population is rapidly aging. It is becoming increasingly susceptible to the catastrophic illnesses that accompany advancing years. So it is our view that the need for both beds and clinics is still there, and this need must be accommodated at least for the balance of this century, as the WW II generation continues to age.

In the Associated Press story that first announced Mr. Nimmo's initiative, he is quoted as saying: "If you have a very active dean of a teaching hospital who can

organize the local politicians and say what a marvelous thing it would be if we had a VA hospital here that would provide outstanding care to the veterans of the community and at the same time bring in 1,500 to 1,800 employment positions, it became a very strong political force. And the local Congressman, of course, listens to that and says, 'Gosh yes, it would be a good thing to have that hospital in my district and support all those people and make the dean of the university happy. And that's sort of the way it evolves.' Well, we just think Mr. Nimmo should be required by this Subcommittee to provide several examples to substantiate that statement.

We do not question that a given Congressman would be happy to have a veterans hospital in his district. But we are absolutely certain this present 172 hospital system did not develop in that fashion. Members of Congress, as a whole are not that irresponsible, and we believe the need for the present locations of hospitals was established in a much more responsible way than Mr. Nimmo says they were.

In the quotation we have used, and in other statements the Administrator either implies or makes reference to "new" VA facilities. We object to these statements because they are inaccurate. The fact is there are no "new" facilities planned for the system. The entire construction program is for renovation and replacement, or correction of space deficiencies in existing facilities, and for correction of fire and safety hazards. The last "new" hospital in the system was added when the VA Medical Center, Tampa, went on line in August 1972—nearly 10 years ago. And the last one before that was the San Diego VAMC that went on line in February 1972. With the Administrator's interest in changing demographics we hardly think he would challenge the demographic justification for hospitals in both Tampa and San Diego.

Which brings us to the matter of the Minneapolis VA Medical Center, which gets prominent mentioning the Administrator's Associated Press statement. He reportedly said: "Does it make sense to spend \$280 million for a replacement VA hospital in Minneapolis where we've got 2,000 empty beds already there and where you've got a declining veteran population."

We have just had an American Legion representative visit the Minneapolis facility, and we can tell you some things about that hospital.

In the first place the Administrator's statement in referring to the 2,000 empty beds "we've got," implies these are VA beds. They are not. The 2,000 empty beds were in the private sector, which overbuilt in Minneapolis—under the auspices of the local Health Systems Agency, which opposes construction of the replacement VA hospital—in an enthusiasm for profit-taking. Since 1979, 1,879 of those surplus beds have been closed.

We also wonder if the Administrator is espousing the plan put forward by some in the private sector, who want to "mainline" VA medical care by putting veterans in beds in the private sector, and have VA pay private doctors through a voucher system for providing their care. The American Legion is categorically opposed to "mainstreaming," for a variety of reasons, the most important of which is that the private sector cannot and will not provide the continuum of care, including its socioeconomic elements, for which VA is responsible.

VAMC Minneapolis is a 55 year old hospital. Its main buildings were erected in 1927. The Outpatient Clinic is housed in a building that went up in 1890. The last addition to the hospital was built in 1950.

VAMC Minneapolis is one of the most sophisticated hospitals in the VA system. It is a tertiary care hospital, with 25 specialty wards, that does most procedures, including kidney transplants and open-heart surgery. It serves as a referral hospital for more than 25 other VA hospitals in a seven state area. On March 24, 1982 it had 651 inpatients in its 738 beds, for an Occupancy Rate of 88.2%.

And as to a declining veteran population, VA's own statistics show an increase in number of veterans in Minnesota, in the immediate last three years from 556,000 to 560,000—which answers both the mortality rate and emigration.

Would this Subcommittee then consider whether VAMC Minneapolis justifies consideration for a replacement hospital? We hope we know the answer to that rhetorical question.

Now let us proceed to the implication in the Administrator's statement that the medical construction program is not justified by current criteria of need.

We will accept the possibility the present system of validation can be improved, and we will support changes to effect improvement. But the present system, as we understand it is projected from the five year plan developed by each hospital in the system. Construction needs identified in the five year plan of each hospital are reviewed by Central Office, and if approved, find their way into the Five Year Plan submitted to Congress by the Agency. Construction recommendations submitted to Congress are subjected to oversight consideration by the Veterans Affairs Commit-

tees of both Houses, and they are also studied before approval by the Appropriations Committees. It is a fact that many changes, including deletions result from these Congressional studies. Is the Administrator implying then that the Congressional Committees are not doing their jobs? We believe the Subcommittee is entitled to an answer to that question.

We proceed now to observations about the procedures established by the Administrator to implement his initiative. In the first place we have been given to understand the service organizations will both be apprized of progress in the review of the construction validation process, and will have opportunity to comment. For this The American Legion is grateful, and we pledge our full cooperation. We will offer our best judgment, as objectively as we can, projected or course, from our obligation to our constituency, the nation's war veterans.

Our initial appraisal of what is being done there is that the new procedure is, essentially an indication of a lack of confidence on the part of agency management in the quality of work performed in this area by the Department of Medicine and Surgery. What is happening is that the Administrator is imposing an entire new layer of management supervision, under the authority of the Deputy Administrator on top of the work ordinarily assigned to DM&S. One of the elements of Congressional oversight of this activity should certainly be to examine into its cost-effectiveness. That, perhaps can only be determined when the new agency function has operated for at least a year, but we do think it is a most important matter for the Subcommittee to watch.

What has happened is the Administrator has established a Facility Planning and Construction Committee (FPACC) "to conduct a comprehensive assessment of the VA's facility planning and construction program." In the material provided us we have identified 16 initial members of the new Committee, to be supported by six subcommittees, or teams.

We wonder whether the Committee, at the outset is so large as to be cumbersome, thus inhibiting both its effectiveness and the speed at which it can accomplish its assigned tasks. However, we will defer to the Administrator's judgment in that matter. Seven service organizations are invited to actively participate in the work of the Committee. That in itself is a large group that could impact on the speed and efficiency of the Committee, although we are pleased and grateful at being included among the seven.

The Committee will have an Executive Director, who is being brought in from outside the VA. We have reviewed the credentials of the person selected for this assignment. They show strong background in both hospital administration and organization. We do not see in them any special background providing expertise in dealing with a system as large as the VA, nor do we see any special background qualifying the individual as an expert in veterans medicine and the rationale that provides the underpinning for the 60 year development of the vast VA health care delivery system. We will certainly work with the Executive Director. We wish to make clear, however that we reserve the right to challenge any decisions that demonstrate a lack of understanding or acceptance of the fundamental mission of the VA system.

The first list of appointees to FPACC included the Inspector General. The propriety of this assignment was first questioned by another of the service organizations. We concurred with this questioning. We understand now the IG will not serve on the Committee, and we believe that office could not do so and provide any objective evaluation of the Committee's work, should that become necessary. We approve the change made in this regard.

The Committee's first task apparently will be to evaluate 56 projects now scheduled for funding in fiscal year 1984, and estimated to cost \$1.2 billion. Nine of these projects were reportedly first questioned by the Inspector General, which is another reason the IG should certainly not serve on the Committee.

The American Legion has no objection to the reevaluation of the 56 projects. Our expectation, depending on the criteria used for the reevaluation is that most if not all of them will be found to be justified. We make that statement based, not on an individual examination of each of the 56, which we certainly have not the time nor the staff expertise to do, but on our certain knowledge, based on reports from our members, and the work of our Field Service that the system is, in fact a deteriorating system needing massive repair and renovation to enable it to fulfill its fourfold mission.

So, here in this statement and at this time, we are not challenging the right or the propriety of the Administrator's initiative to revalidate the medical construction program for the VA. Cost-effectiveness and real need are high on the priority list of all conscientious citizens.

We wonder whether there were not mechanisms already available to the Administrator to accomplish this goal. We wonder whether this added layer of management will in fact render the operations of the agency more efficient. We have an apprehension the much needed renovation and replacement program could get bogged down in a bureaucratic tangle that could slow the program, thus delaying needed improvements in the system, and escalating costs in these times of inflation.

We wish at this time to assure this Subcommittee it is our intention to work as closely with FPACC as we are allowed to do. If problems develop we hope for permission to bring our concerns to the Subcommittee, with the confidence it will continue to intensively pursue its oversight function. We believe the Committee on Veterans Affairs shares our belief in the importance of the VA health care delivery system, and is committed to maintenance of its ability to provide high quality care to the nation's sick and disabled veterans.

Before we conclude we beg leave to say a word about a matter contingent, but not directly related to the subject we are here to discuss. We refer to a Federal Capital Budget. This idea, as we understand it would change the Federal Budgeting system to place funding of the capital plant of the Federal Government on a different basis than that used to provide operating funds.

The American Legion has no essential objection to this idea. Neither are we sufficiently well informed about it to make a final judgment as to its advisability as it would relate to the Veterans Administration.

We do understand the nature of the problems the Capital Budget would be intended to deal with. We can see the idea might make it possible to identify and respond to the capital needs of the Government. It would require fundamental changes in the present budgeting and funding process. These changes require in-depth study, evaluation and planning before they could ever be implemented.

This entire matter is an extremely complex and important one. We simply do not know whether Capital Budgeting is an idea whose time has come for the Federal Government. We would think it might perhaps be approached through appointment of a Congressional Task Force with staff to undertake the studies and planning needed before a definitive assessment is made by the entire Congress in concert with the Executive.

We thank the Subcommittee again for the opportunity to present our views at this time.

STATEMENT OF JOHN F. HEILMAN, NATIONAL LEGISLATIVE DIRECTOR, DISABLED
AMERICAN VETERANS

Mr. Chairman and members of the subcommittee, on behalf of the 708,000 members of the Disabled American Veterans, may I say that we deeply appreciate this opportunity to present our views on the Veterans Administration's Medical Planning and Construction Program.

Mr. Chairman, pursuant to Section 5004, Title 38, USC, the process governing annual Congressional appropriations of funds for major VA medical care construction projects (in excess of \$2 million) and leasing of space (in excess of \$500,000) requires positive action by the House and Senate Veterans Affairs Committees. Today's hearing will obviously provide insight to the deliberations of the Subcommittee and full Committee in preparation for its resolution of approval relative to fiscal year 1983 VA medical care construction.

With reference to fiscal year 1983, it goes without saying that the DAV strongly supports the funding proposed in the VA budget request—\$576.7 million in total medical construction (up \$136.2 million over fiscal year 1982) with over \$300 million slated for replacement/modernization of VA hospitals, nursing homes and outpatient clinics.

Having stated this, Mr. Chairman, I would like to focus my remarks today on the five year construction planning process of the VA and discuss such process relative to (1) the recently announced plan of the VA Administrator to "revalidate" all major VA medical care construction projects potentially eligible for funding commencing in fiscal year 1984 (and the out years) and (2) the establishment, by the Administrator, of a top level Facility Planning and Construction Committee (FPACC) that is charged with conducting a comprehensive assessment of the VA's planning and construction program (FPACC has also been given the immediate task of "guiding" the revalidation of proposed fiscal year 1984 construction).

Mr. Chairman, we are all aware that in recent years, maintenance of a separate medical care system for provision of direct health care services to our nation's veteran population has been severely criticized. The Office of Management and Budget,

self-appointed policy-makers such as the Heritage Foundation and certain interests in the private medical community have all, in one form or another, inhibited proper maintenance of existing VA medical facilities and/or attempted to thwart necessary expansion and improvement of the system.

These "critics" of VA health care have been vocal, powerful and persistent. Assuming that their persistence shall continue, we fully realize that our hospital system can best be defended if the criteria governing its maintenance and expansion is, in turn, defensible.

Therefore, Mr. Chairman, I can state that the Disabled American Veterans is not opposed to any VA effort aimed at assuring that hospital construction planning is based upon an accurate, up-to-date assessment of the health care needs of our nation's veteran population. Indeed, we welcome such initiatives and we are aware that this Subcommittee holds similar views.

Yet, Mr. Chairman, the DAV feels obligated to voice certain reservations concerning the VA's recently initiated FPACC and the immediate mission given to it—revalidation of fiscal year 1984 construction projects.

First of all, one would assume that, under VA's current long-range planning process, essential considerations such as project options, conceptual alternatives, changes in health care eligibility, shifts in veteran demographics and the like would all have played a fundamental role in determining current and out year medical care construction. Given the creation of FPACC, are we now being asked to believe that such an assumption is incorrect?

And if the answer to this question is "yes" and the current advance planning process has been deficient in some respects, why not require existing planning personnel to formulate and provide new long-range planning guidelines? Either that or charge the two year old Medical District Initiated Program Planning process (MEDIPP), in conjunction with the Office of Construction and whomever else is necessary, to assume this task.

In short, Mr. Chairman, in view of the stated mission of FPACC and the existence of the present apparatus within VA to handle such a mission, why create an entity of the magnitude that FPACC appears to be to do the job? And why, in view of the fundamentally important decisions that FPACC will be making vis-a-vis the future of VA health care planning in this country, place as its Executive Director an individual of admittedly impeccable professional credentials, but one who has no practical experience whatsoever with our VA health care system?

Frankly, Mr. Chairman, the DAV was quite concerned over the relatively short period of time that elapsed between creation of FPACC (February 1, 1982) and the announced intention of the VA Administrator to "revalidate" all fiscal year 1984 major health care construction (February 19, 1982). Our concern was heightened considerably as the latter announcement was simultaneously accompanied by public statements on the part of the VA Administrator which seemed (to us) to indicate his belief that:

1. VA hospital construction planning in the past has been primarily influenced by political considerations on the part of the Congress, rather than on established planning criteria.

2. VA hospital/medical school affiliation has not been beneficial (to the system) and could contribute to excessive medical research, an oversupply of hospital beds and a national surplus of doctors.

3. Major VA health care construction should be inhibited in those areas where there exists an excess amount of unused hospital beds in the private sector.

The last "point" was buttressed (by the Administrator) with a specific example—the proposed VA replacement hospital in Minneapolis, Minnesota. The DAV has only to recall that, in July of 1980, the House of Representatives overwhelmingly demonstrated that the claim of "over-bedding" in the private sector is, at best, a specious argument to employ against proposed VA hospital construction.

We have voiced our concern to the VA, Mr. Chairman, and it would be improper for me not to state that the Administrator has informed us that our fears are ungrounded. I will also say that the DAV and other veteran organizations have been thoroughly briefed on FPACC and our input has very definitely been solicited on a continuing basis.

Yet, for every overture such as this—welcomed as it is—there comes again that "cause for concern."

Coincidental with reassurances received concerning the mission of FPACC and revalidation of fiscal year 1984 medical care construction, we have learned that, through an unannounced visit by personnel from the office of VA Inspector General, the Director of the Dallas VA Medical Center was recently informed that he should suspend subcontracting negotiations for a 120 bed nursing home care unit for

which ground has already been broken. When the Director inquired as to the justifications for such an action, vague statements alluding to the "excess of hospital beds" in the private sector were given by the IG personnel. When further questioned (by the Director) as to the types of excess hospital beds—were they class I or class II, etc.?—the IG personnel professed ignorance.

This, Mr. Chairman, is "OMB type" revalidation and it should not be allowed to continue.

In summation, Mr. Chairman, the DAV urges the Subcommittee to continue to make strong use of its oversight function in the area of VA health care. In particular, we ask that you monitor the actions of FPACC most closely, especially with reference to the revalidation of Fiscal Year 1984 medical care construction projects.

In closing, may I again state our appreciation for being allowed to participate in today's hearings.

STATEMENT OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE,
VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the subcommittee, thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab, and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, the Veterans of Foreign Wars finds no fault with the site selections of the Veterans' Administration listing those medical facilities most in need of construction, replacement, or major modernization as outlined in their five-year plan dated June 1981.

We are cognizant of the General Accounting Office report of last December entitled "Opportunity to Reduce the Cost of Building VA Medical Facilities." The thrust of the report deals with cost overruns and the various reasons for such added expenditure. The seriousness of the problem is reflected in the statement "the staff found that cost estimates for 28 major hospital construction projects had increased an average of 81 percent from their original budget submission to the Congress."

Mr. Chairman, construction cost overruns are not at all peculiar to the Veterans' Administration because of high inflation rates. The VA is placed in particularly difficult position with respect to cost containment since five to six years elapse between the first appropriation for hospital construction and completion of the facility. However, it would appear cost overruns attributable solely to design and construction modifications are controllable factors which could and should be greatly reduced by more thorough planning and more stringent review. The suggestion of GAO to reduce construction time by as much as 15 months and costs by perhaps 11.6 percent by extending the Advance Planning Fund to allow the VA to contract for final designs while Congress reviews projects is worthy of serious consideration.

Mr. Chairman, the Veterans of Foreign Wars is highly disturbed with the moratorium placed on construction by the Administrator of Veterans' Affairs, and we view with alarm his gratuitous and belittling public comments with respect to veterans and their authorized medical care.

Mr. Chairman, prior to enactment of Public Law 96-22 the location of each new VA medical facility was determined by the Administrator of Veterans' Affairs, subject to the approval of the President. Under current law approval by both the Senate and House Veterans' Affairs Committee is required for construction projects costing more than \$2 million or annual leases exceeding \$500,000. All construction projects have been fully justified by the VA and approved at the highest level.

The purported purpose of the moratorium is to revalidate previously approved construction projects. To this end the Administrator has established a Facility Planning and Construction Committee (FPACC) consisting of six teams selected by the head of the Department of Medicine and Surgery, and the Offices of Construction, Budget and Finance and the Inspector General. The FPACC has been directed to establish liaison with several veterans organizations, and our VFW representative is the Director of our National Veterans Service.

Mr. Chairman, while demographic changes in the veteran population may, indeed, justify construction modifications several years hence, we hope that the construction moratorium and FPACC do not, in fact, constitute a subterfuge to support the Congressional Budget Office proposal to close 30 VA hospitals to save \$1.8 billion in the next five years. You will recall that in making this proposal CBO opined that the remaining hospitals "... should be more than adequate to handle the needs of all

service-disabled veterans . . ." Placing all these pieces of the montage together it would appear that there is a well thought out plan to greatly reduce medical care for our nation's veterans, particularly those in need with non-service connected disabilities. In this connection. We are not at all reassured by the Administration's request, denied by this Committee, for \$500,000 for a study to determine the feasibility of collecting a user fee for medical services to non-service-connected disabled veterans not in receipt of pension. Can you envision such a proposal when we do not even consider such a contribution by welfare recipients who may never have done anything for our nation but take?

Mr. Nimmo was recently quoted by the Associated Press as asking, "Does it make sense to spend \$280 million for a replacement VA hospital in Minneapolis where we've got 2,000 empty beds already there and where you've got a declining veteran population?" Mr. Chairman, if 2,000 empty beds do exist in Minneapolis, and we question this ascertainment, they are not in VA facilities but in community hospitals overbuilt and overbedded for personal private financial gain. Figures published by the VA reflect no reduction in the veteran population of Minneapolis Regional Office Area in the past year. Furthermore, few VA hospitals have been revalidated to the extent of the 55 year old Minneapolis hospital.

Mr. Chairman, the Administrator's words have the sound of "mainstreaming" veterans' health care as proposed by the Office of Management and Budget in March of 1981, and alluded to by the President in a construction deferral last October. Although repeatedly denied by the Administration that "mainstreaming" is their intent, the language of "mainstreaming" continues to surface at the highest levels. I am certain you know that any proposed expanded use of non-VA resources for veterans medical care would be opposed by the VFW with vigor.

In addition to the foregoing, Mr. Chairman, the Administrator has made unfortunate remarks with respect to veterans and their entitlement to medical care provided by the VA. Before the full Committee last month, he branded wartime service as a mere "inconvenience", labled VA medical care as "free medical care", and stated that "people have an obligation to serve their country and are not necessarily entitled thereby to a permanent social welfare system.

Mr. Chairman, wartime service has never been a mere inconvenience as those of us who have served know. As for service during war or hostilities being a responsibility of citizenship, that will only be true again when there is no educational deferment from the draft and no wholesale pardon for draft dodgers. Free medical care? A permanent social welfare system? Those veterans with service-connected disabilities have paid dearly for the continued care owed them by a grateful nation. For veterans in need suffering from non-service connected disabilities, the special service they rendered placing them properly above the social welfare system was first recognized by Congress in the passage of S. 2257 which because Public Law 242 of the 68th Congress on July 7, 1924. Quoting in part, the law authorized ". . . hospitalization and necessary traveling expenses to veterans of any war, military occupation, or military expedition since 1897, not dishonorably discharged without regard to the nature or origin of their disabilities: provided that preference to admission to any government hospital for hospitalization under the provisions of this subdivision shall be given to those veterans who are financially unable to pay for hospitalization and their necessary traveling expenses."

I believe it pertinent at this time to point out that with 89,269 hospital and nursing care beds the VA is presently in violation of so much of Public Law 97-72 which mandates the Administrator to operate and maintain a total of not less than 90,000 hospital and nursing home beds.

Mr. Chairman, resolutions passed by the voting delegates to our 82nd National Convention addressing the issue at hand and appended to my testimony are the following:

Resolution No. 723 entitled, "Replacement of Veterans Administration Medical Center, Allen Park, Michigan."

Resolution No. 724 entitled, "Opposing the Closing of VA Hospital at Fargo, North Dakota."

Resolution No. 726 entitled, "Establishment of an Out-Patient Clinic in Redding, California."

Resolution No. 727 entitled, "Establishment of an Out-Patient Clinic in Bakersfield, California."

Resolution No. 734 entitled, "Oppose AMA Proposals to Assign Military Veterans to Private Hospital Facilities."

Resolution No. 740 entitled, "Oppose Reductions in VA Medical Facilities and Closures of VA Regional Offices."

This concludes my testimony, and I will be happy to respond to any questions you may have.

RESOLUTION No. 723, REPLACEMENT OF VETERANS ADMINISTRATION MEDICAL CENTER, ALLEN PARK, MICH.

Whereas, for the past fifteen years, the Department of Michigan, Veterans of Foreign Wars of the United States, has made attempts to have the Veterans Administration Medical Center, Allen Park, Michigan, replaced with a new facility; and

Whereas, Veterans of Foreign Wars' hospital surveys conducted in February 1975 and again in February, 1978, revealed findings that justified an early replacement of the Allen Park facility and further, the VFW conclusions were confirmed by a special study (identified as the Rossetti Report) which was conducted on orders from the Congress of the United States, and the hospital should be replaced; and

Whereas, in compliance with Public Law 96-22, Section 5007, the Veterans Administration has announced a list of ten hospitals most in need of construction, replacement or major modernization, and Allen Park is ranked number six; and

Whereas, in response, the VA is now engaged in a comprehensive study of this facility, but it is fearful that an effort will be made to modernize this station to save construction dollars over the next five years without regard for the fact that Allen Park Hospital has built-in deficiencies that cannot be corrected; and

Whereas, over a period of time from a cost effectiveness aspect, it would cost the VA more to operate this hospital than it would to build a new medical center adjacent to Wayne State School of Medicine: Now, therefore, be it

Resolved by the 82nd National Convention of the Veterans of Foreign Wars of the United States, That the Administrator of Veterans Affairs be urged to seek funds for the replacement of the Allen Park Veterans Administration Medical Center to be constructed adjacent to the Wayne State School of Medicine, Detroit, Michigan; and be it further

Resolved, That the Allen Park Veterans Administration Medical Center not be closed after the new hospital becomes operational but be used for treatment of psychiatric disorder, intermediate care, nursing care patients, and domiciliary care.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

RESOLUTION No. 724, OPPOSING THE CLOSING OF VA HOSPITAL AT FARGO, N. DAK.

Whereas, information has been received that Acting VA Administrator Rufus Wilson, in testimony on March 10, 1981 before the House Subcommittee on Appropriations for HUD Independent Agencies, said the VA "will consider closing hospitals," in the spring review with OMB; and

Whereas, one of the hospitals slated for closing was the VA Hospital located at Fargo, North Dakota: Now, therefore, be it

Resolved, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, That we go on record opposing any such closing intent.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

RESOLUTION No. 726, ESTABLISHMENT OF AN OUT-PATIENT CLINIC IN REDDING, CALIF.

Whereas, Under the provisions of Title 38, United States Code of Veterans benefits and Public Law 95-126 which authorizes the Administrator of Veterans Affairs to provide medical care to eligible veterans; and

Whereas, one of the many functions of the Veterans Administration is to provide adequate Hospital service to sick and disabled veterans of the Armed Service; and

Whereas, these medical facilities are not readily available to the vast majority of veterans in this area the nearest Veterans Administration Hospital is in excess of 100 miles in distance; and

Whereas, with a shortage of doctors in this area, even with an out-patient treatment card that authorizes local treatment, it is extremely difficult to find a doctor that will honor it: Now, therefore, be it

Resolved, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, That we petition the Veterans Administration to establish a full time out-patient clinic in Redding, California with a population in excess of 368,000 and a

distance in excess of 100 miles to the nearest Veterans Administration Medical Hospital facilities.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

RESOLUTION NO. 727, ESTABLISHMENT OF AN OUT-PATIENT CLINIC IN BAKERSFIELD, CALIF.

Whereas, under the provisions of title 38, United States Code of veterans benefits and Public Law 95-126 which authorizes the Administrator of Veterans Affairs to provide medical care to eligible veterans; and

Whereas, one of the many functions of the Veterans Administration is to provide adequate hospital service to sick and disabled veterans of the armed services; and

Whereas, these medical facilities are not readily available to the vast majority of veterans in this area as the nearest Veterans Administration hospital is in excess of 100 miles in distance; and

Whereas, winter weather has made the trip to the VA facilities south by automobile impossible due to highway closure for prolonged periods due to snow, and the altitude of the mountain range could be most hazardous to veterans with certain types of medical problems; and

Whereas, with a shortage of doctors in this area, even with an out-patient treatment card that authorizes local treatment, it is extremely difficult to find a doctor that will honor it. Veterans with chronic diseases must, periodically travel over this mountain pass to see a doctor or refill their prescriptions: Now, therefore, be it

Resolved, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, That we petition the Veterans Administration to establish a full time out-patient clinic in Bakersfield, California with a population in excess of 700,000 and a distance in excess of 100 miles to the nearest Veterans Administration medical hospital facilities.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

RESOLUTION NO. 734, OPPOSE AMA PROPOSALS TO ASSIGN MILITARY VETERANS TO PRIVATE HOSPITAL FACILITIES

Whereas, The American Medical Association (AMA) has under consideration proposals to request assignment of military veterans seeking health care to private hospitals instead of to the usual Veterans Administration hospital facilities; and

Whereas, Currently there are in excess of 130,000 empty beds available in the private hospitals of this nation; and

Whereas, Planned reduction of medical personnel in the VA hospital system would force the elimination of service to about 20,000 bed spaces by 1982; and

Whereas, Such proposals of the AMA, if implemented, would deny to vast numbers of eligible veterans their legal entitlement to health care from the VA hospital system; and

Whereas, Veterans with unique service-connected disabilities would find inadequate the sources of treatment in hospital facilities geared to the medical problems of the civilian population; and

Whereas, This proposed anti-veteran social-welfare-planner treatment of sick and disabled veterans would obviously reduce them to the status of welfare patients: Now, therefore, be it

Resolved by the 82nd National Convention of the Veterans of Foreign Wars of the United States, That we resist most strenuously all attempt to force the Veterans Administration to adopt the American Medical Association proposals to utilize private hospital facilities instead of the VA hospital system for the health care of qualified sick and disabled military veterans.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

RESOLUTION NO. 740, OPPOSE REDUCTIONS IN VA MEDICAL FACILITIES AND CLOSURES OF VA REGIONAL OFFICES

Whereas, the Reagan administration has proposed drastic reductions in the Veterans Administration 1982 budget above and beyond the previous proposed Carter budget; and

Whereas, the proposal provides for the delay in construction, reductions in beds and in some instances, total closing of VA medical facilities; and

Whereas, the proposed reductions in funds will not only cause the closing of beds, but will reduce medical services to the nation's war veterans; and

Whereas, the need for medical services continues to increase due to the advancing age of the World War II veterans: Now, therefore,

Resolved by the 82nd National Convention of the Veterans of Foreign Wars of the United States, That we go on record opposing the administration's proposed cut in the Veterans Administration budget and the reduction of services to the nation's war veterans, including the proposal to eliminate or delay construction of medical facilities and closing of State VA offices; and be it further

Resolved That, we petition members of the Congress to oppose the planned reduction in VA medical facilities that would eliminate or curtail medical services to the nation's war veterans and vigorously oppose the closing of the VA Regional Office in each of the States and to hold President Reagan to his campaign promise to not reduce any veterans benefit and to provide the necessary funding for those programs.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

TESTIMONY OF GABRIEL P. BRINSKY, AMVETS NATIONAL SERVICE AND LEGISLATION
DIRECTOR

AMVETS appreciates this opportunity to present its views concerning the Medical Construction Program of the Veterans Administration. Realizing the restraints of time placed on the Committee, I will briefly summarize the AMVETS views and request that my statement be incorporated into the record.

Our concerns regarding the Veterans Administration facility planning and construction program can perhaps be best expressed by focusing upon one Veterans Administration Hospital, that of the Minneapolis VA Medical Center.

In April 1980, AMVETS appeared before the Senate Veterans Affairs' Committee and testified regarding the Minneapolis VA Medical Center as follows: "As for the construction of the hospital in question, knowing the methodology and the extensive studies conducted by the Veterans Administration, we have had no occasion in the past to materially disagree with any decisions which the Department of Medicine and Surgery and the Administrator have made in regard to the construction, maintenance, or site locations of hospitals.

"We would like to go on record to express our agreement with the proposed construction * * *"

This testimony reflects the confidence and working relationship which AMVETS had with the Veterans Administration pertaining to the facility planning and construction program after receiving the input of the various service organizations. It was only recently we were told, in effect, that the VA Hospital Construction Program as previously proposed was inadequate being made without regard to demographics and other factors. It was announced that the VA Medical Construction Program proposed for Fiscal year 1984 and later would require revalidation in order that it may be defensive when presented to Congressional Committees. This came as a surprise and much to our disillusionment. A Facility Planning and Construction Committee was established by the Administrator which would be charged with a comprehensive assessment of the VA's Facility Planning and Construction Program.

What is of a disturbing significance is the fact that the 5-year hospital plans for the Veterans Administration have in the past been accepted. As required by law, the Committees of Congress have approved the proposed constructions. Congressional hearings on the construction of these facilities have been conducted. Extensive time and study by the Department of Medicine and Surgery has been devoted to these programs. And all of a sudden, we find that what was done is now considered as unacceptable. We certainly laud the Veterans Administration's desire to review its effectiveness and to assess its direction. But it is the very question of direction which offers some apprehension particularly when viewed with the response of the Administrator during a recent press interview to the effect that the Veterans Health Care System might be a contributing factor to the oversupply of civilian hospital beds. Apparently the 2,000 empty beds in non-VA hospitals in Minneapolis may have influenced the Administrator's thinking. In any event, these statements coupled with his comments in a letter dated March 17, 1982, addressed to the Honorable Alan Cranston the Ranking Minority Member of the Committee on Veterans Affairs, and disturbing. In that letter, the Administrator stated that the Veterans

Administration is required under OMB Circular A-95 to provide state and area wide clearing houses with an opportunity to coordinate review of proposed VA major construction projects with the appropriate Health System Agencies, State Health Planning Agency, and other affected agencies and consider such agencies' comments. He continued by stating that the Veterans Administration appreciated the input of community help providers and is sensitive to the concerns that we complete or duplicate private sector medical resources.

And therein lies the problem, as AMVETS sees it. It appears that the Veterans Administration is embracing the position of the Office of Management and Budget wherein it would inextricably join the Veterans Administration Planning and Construction Program with the needs of the private sector. It is and always has been the position of AMVETS that the problems created in the civilian sector by an overage of beds currently somewhere in the neighborhood of 130,000 was not the responsibility of or an obligation of the VA. Our health care requirements are different and so are our needs. The Veterans Administration facilities are not confined to the treatment of patients within defined districts but draw upon many jurisdictions. For example in Minneapolis, it services approximately 87 counties of Minnesota.

To summarize, we are always in favor of reassessment and revalidation. It is the "direction" which Mr. Nimmo referred to in his letter to Senator Cranston which causes us some alarm.

On April 8, 1980, in a hearing before the Committee on Veterans Affairs, United States Senate, Dr. Herbert M. Baganz, Assistant Chief Medical Director for Planning and Program Development, Department of Medicine and Surgery of the Veterans Administration testified concerning the critical need for replacing the Minneapolis VA Medical Center. His testimony was directed towards demonstrating the immediate need to replace the antiquated medical facility at the Minneapolis VAMC site with a modern health-care facility commensurate with the quality of care and health-care mission of that medical center.

During his testimony he pointed out that while the Minneapolis metropolitan area hospital community was overbedded, he noted that the Minneapolis health service area consisted of seven counties while the VA primary service area consisted of 72 counties which, in his opinion, demonstrated the need for the VA to plan from a much broader perspective. He felt that the replacement of the VA facility would not add beds to the area but would simply provide the Veterans Administration with a safe and functionally sound facility to continue supporting tertiary care mission of the health care center.

Brooks Martin, Health Care Facilities Specialist from the Office of Construction of the Veterans Administration, testified as to the methodology employed in establishing the needs of a VA Medical Facility. No serious opposition was raised by those who were to testify from the private sector.

Malcolm Mitchell, Executive Director of the Metropolitan Health Board of St. Paul, Minnesota, views the construction of the VA facility as a central part of the community. He testified that approximately 40 to 50 percent of the patients originated within the seven county area of Minneapolis and in the Health Board's belief all hospitals needed to participate in the planning process and that the veterans should be a part of that process.

By reason of a request by the Veterans Administration in February of 1980 to conduct an A-95 Review Process, there was appointed from the Health System Agency Board a project committee whose role was to look into the relationship of the Minneapolis VA Hospital in the VA system with the local community. While recognizing the needs of the veterans population for high quality care and the role of the Minneapolis Veterans Hospital in the upper midwest region, the committee did consider the fact that they did have in the metropolitan area an excess in capacity of hospital services in the area and that there was a need to consolidate, to merge, to share some specialized services wherever possible to help contain the rise in health care costs.

Testimony was also offered at that hearing by Lynn Kiehne, Associate Director of the Council of Community Hospitals, to the effect that they do question whether our veteran population could be better served if they were given a choice to obtain health care at any facility of their choice. The suggestion was that by providing veterans medical benefits through a voucher system it would result or offer prospects for a quality health care better than now available through providing them with several options. Thus, the proper size of a proposed new VA hospital construction could be determined through a process of a veteran's choice. The veterans who prefer the VA could use their services while others would have their needs served at the facilities of their preference.

As we view it, the Veterans Administration Health Care System has been established by a generous nation through its Congress to provide for those who have served. The Veterans Administration Health Care System is the most efficient system of its kind in the world. It is cost efficient and productive. It provides a purpose for which it was established. There are those who would absorb it into the private sector for various reasons. Prognostications have it that there will be a surplus of physicians in the years to come. A solution to such a situation would be to voucher in the health care of veterans. The private sector is experiencing a surplus of hospital beds. A potential or partial solution to the problem would be to convert these beds to veteran use again through a vouchering in system. While we do believe that as veterans we have a part to play in all community activities, we are not of the opinion that the veterans should be called upon to sacrifice a health care system in order to extricate a situation which has been created by the civilian sector. We are of the conviction that since the present VA health care system provides the most effective means for taking care of its veterans, as promised by the Congress of the United States, then it should be continued until such time as it is established that there is a better way to do it. Until then, AMVETS will oppose any encroachment upon the current system.

The attached list is of projects currently scheduled to have both their preliminary design and cost estimate completed by October 1982 and therefore available for inclusion in Fiscal Year 1984 budget. We requested that this be incorporated as part of the record.

Thank you.

PROJECTS FOR REVALIDATION—MAJOR FISCAL YEAR 1984, AS OF MAR. 5, 1982

(Dollars in thousands)

Medical center	Medical region	Project identification	Project title	P.P. comp	Cost
Alexandria, La	3	502-058	Clinical improvements and relocate support function.	June 1982.....	\$30,000
Amarillo, Tex	6	504-026	Addition/renovate clinical support	June 1981.....	44,000
Bath, N.Y.	1	514-068	Renovate building 78 for NHC.....	December 1980	7,200
Battle Creek, Mich	4	515-083	Renovate building 82 (first and second floors—patient privacy).	February 1982	5,800
Beckley, W. Va. ¹	2	517-013	Clinical addition and alterations.....	October 1980	25,000
Biloxi, Miss. ²	3	520-056	Modernize various buildings (buildings and grounds).	September 1982	87,300
Brockton, Mass	1	525-016a	Modernize buildings 2 and 7.....	August 1982	29,500
Brockton, Mass	1	525-021	Addition and renovation for SCI.....	June 1982.....	6,800
Buifalo, N.Y. ¹	1	528-039	Res. and education facility	March 1981	27,400
Castle Point, N.Y.	1	533-056	Building addition.....	May 1981	15,000
Charleston, S.C.	3	534-015	Clinical addition	April 1982	20,000
Cheyenne, Wyo.....	5	442-023	Exp/renovate building 1 (clinical function).	November 1982	7,700
Chicago (Westside), Ill. ²	4	537-024	OPC addition/renovate buildings 11a and 11b.	January 1982.....	40,500
Cincinnati, Ohio. ³	4	539-026	Upgrade electrical distribution	March 1982.....	3,000
Clarksburg, W. Va	2	540-008	Clinical addition and alterations.....	December 1982	15,000
Cleveland, Ohio.....	4	541-021	Clinical improvement (surgical service relocated).	April 1982.....	15,000
Durham, N.C.....	2	558-025	Additional elevators	December 1981	4,300
East Orange, N.J.	2	561-034	Reloc./consol. res.....	October 1982	5,300
East Orange, N.J.	2	561-035	120-Bed NHCU	February 1983	15,000
Fayetteville, N.C. ¹	2	565-027	Clinical addition	April 1982.....	15,800
Fresno, Calif	6	570-019	Clinical addition (dental, surgical, RMS, et cetera.)	November 1982	10,000
Hines, Ill. ¹	4	578-096	New warehouse/service building	October 1981.....	11,000
Hines, Ill.	4	578-097	HVAC buildings, 50, 51 and 53	February 1982	44,000
Hot Springs, S. Dak. ¹	5	579-040	Clinical addition	August 1980	14,700
Lake City, Fla.....	3	534-036	OP and clinical addition.....	August 1982	6,000
Leavenworth, Kans. ³	5	686-062	F&S improvements (exit and sprinklers) ..	March 1982	7,500
Leavenworth, Kans. ¹	5	686-060	208 domiciliary.....	July 1981	14,900
Livermore, Calif. ³	6	599-054	Fire and safety improvements	July 1982.....	3,500
Loma Linda, Calif	6	605-004	60-bed NHCU	October 1982.....	6,000

Footnotes at end of table.

PROJECTS FOR REVALIDATION—MAJOR FISCAL YEAR 1984, AS OF MAR. 5, 1982—Continued

[Dollars in thousands]

Medical center	Medical region	Project identification	Project title	P.P. comp	Cost
Los Angeles (WAD), Calif.	6	691-090	Renovate buildings 212, 214 and 217 for DOM.	September 1981	\$17,300
Los Angeles (WAD), Calif.	6	691-098	120-bed NHC (conversion) building 213 (phase II).	March 1982	10,500
Lyons, N.J.	2	604-064	120-bed NHCU	August 1982	18,200
Manchester, N.H.	1	608-014	Laundry, warehouse, engineering facility	October 1982	10,000
Martinez, Calif.	6	612-018	120-bed NHCU	June 1982	14,400
Miami, Fla.	3	546-014	120-bed NHCU	August 1982	16,000
Minneapolis, Minn. ^{1 2}	5	615-001	Replace hospital buildings	June 1982	294,000
Montgomery, Ala.	3	619-020	OPC addition	September 1980	18,100
Newington, Conn.	1	627-032	Addition to buildings 1 and 2	April 1980	45,000
New York, N.Y. ³	1	630-025	Upgrade electrical distribution, phase II	October 1978	4,000
Northport, N.Y.	1	632-062	120-bed NHCU	September 1982	13,800
Omaha, Nebr. ¹	5	636-022	OPC addition	September 1980	24,200
Perry Point, Md.	2	641-079	New laundry building	August 1982	18,500
Pittsburgh, Pa (UD). ²	2	646-024	OPC addition	February 1982	22,680
Pittsburgh, Pa (HD)	2	645-017	Laundry	October 1982	12,000
Pittsburgh, Pa (UD)	2	646-025	Centralized warehouse facility	October 1982	4,200
Prescott, Ariz. ¹	6	649-047	200-bed DOM/60-bed NHC	March 1981	30,000
Providence, R.I.	1	650-025	60-bed NHC	October 1982	6,500
Richmond, Va.	2	651-003	Automated transport system	May 1978	4,200
Roseburg, Oreg.	6	653-027	OPC addition	February 1982	28,000
Salem, Va. ²	2	658-038	Renovate building 76 (intermed)	April 1977	5,510
San Antonio, Tex.	5	671-009	Supply warehouse and SPD	June 1979	5,800
San Francisco, Calif.	6	662-043	120-bed NHCU and parking	June 1982	14,400
Sioux Falls, S. Dak. ¹	5	438-020	Clinical and support service	October 1982	21,000
Syracuse, N.Y. ³	1	670-016	F&S improvement, patient privacy and support system.	May 1981	12,000
Tomah, Wis.	4	676-031	Modernize buildings 406 and 408	September 1982	5,400
Waco, Tex.	5	685-041	Construction—new dietetic building	March 1981	8,400
56 projects, total.					1,221,290

¹ Questioned by Inspector General.² Split funded.³ Fire/Safety. The projects are ones which appear to entail direct patient safety. If so, they will be excluded from the revalidation process.

Note: Some of the projects on the following list indicate a preliminary completion date later than October 1982. These projects were included at the request of D.M. & S. as the potential exists prelims could be completed earlier in time for the fiscal year 1984 budget submission.

A MESSAGE TO VETERANS RECEIVING CARE FOR NON-SERVICE-CONNECTED CONDITION

The veteran population in the State of Florida continues to grow at a staggering pace. As a result of the services the VA Medical Center, Miami provides are being taxed beyond its resources. It is therefore necessary that we curtail outpatient services to non-service connected veterans who are not legally entitled to priority outpatient treatment on a continuing basis and to service connected veterans rated less than 50 percent who need out patient services for non-service connected conditions. We are therefore implementing the following policy change.

Upon your admission to the hospital or outpatient treatment program we will immediately begin your pre-discharge planning. After discharge from the hospital, if follow-up treatment is indicated, you will normally be expected to receive this treatment from your private physician at your own expense. If our physician staff determines that follow-up treatment is indicated by the VA you may be placed on a treatment program not to exceed 6 months duration. At this time time you will be discharged from the program or referred to your private physician at your own expense. If you do not have a private physician you may elect to see a social worker who will assist you in locating the appropriate community resource for continuation of care. The same time limitation for outpatient treatment will apply to veterans

who are placed in the Ambulatory care program; obviate the need for hospitalization.

We regret that this action is necessary; however, if we are to continue to provide the highest quality of care to the veterans we serve, these steps are required.

T. C. DOHERTY, *Director.*

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

FROM HON. RONALD M. MOTTI TO ADMINISTRATOR NIMMO

Question 1. Mr. Nimmo, you are quoted in an Associated Press article as saying, "The best way to protect it is to give it credibility." You are referring to the VA's health care delivery system. You further state, "The question comes down to: are we building for the veteran, to meet his needs, or are we building for some other purpose?" Would you fully explain this statement please.

Answer. My statement reflected the findings of Congress, the General Accounting Office, and the VA's Inspector General that significant improvements were needed in the Agency's planning, project prioritization, and construction process. Based on my own assessment, I agree with these findings. The VA's current planning and construction program needs to be refined and improved to better reflect established, long-range health care priorities; sensitivity to construction costs; and most importantly, the needs of the veteran population. The Agency also needs to improve its ability to justify and effectively allocate limited budget resources. We are taking steps to correct these deficiencies and hope that the Medical District Initiated Program Planning (MEDIPP) process, once on-line, will effect significant improvements.

My statement also reflected the reality that the environment in which the VA health care delivery system operates is one characterized by multiple groups which take an active interest in the VA's construction program. Our medical centers, veterans groups, our affiliated medical schools, and staff elements within the VA all are actively involved in the Agency's health care facilities program, and often strongly support certain health program areas. We need to be responsive to these groups, but in doing so, we must ensure that our overall planning effort is guided by substantial veteran health care needs translated into coherent long range construction priorities designed to meet those needs.

Question 2. You imply that all of the projects under your review have been approved by the Congress and are scheduled to be built in fiscal year 1984 or later. You further say that this total amounts to \$2.7 billion worth of new, modernized or replacement hospitals, clinics, nursing homes, and domiciliaries. Please tell us where we may find the document that you refer to as containing Congressional approval of this amount of construction funds.

Answer. The \$2.7 billion figure I referred to in a press interview was a very rough estimate, based on my memory of the projects in the VA's current Five Year Plan for fiscal year 1984 or later years. I did not intend to imply that Congress had approved these projects for construction funding.

Question 3. Mr. Nimmo, in your March 17, 1982 letter to Senator Cranston, you state that the design work on the Minneapolis project will not be halted during the revalidation review and will continue on schedule unless the review indicates that it should be changed in scope. Will this include the necessary site preparation in order to expedite the construction of the replacement facility?

Answer. While the VA requested money for both design and site preparation and both Veterans Committees approved that request, the actual language in the appropriation act used the word design and omitted the phrase "and site preparation."

The legislative history does not indicate that the appropriations committee purposely omitted the site preparation language. For example, the \$15 million requested was not reduced by an amount equal to the cost of site preparation.

We are presently taking action to clarify the scope and extent of our authority.

Question 4. We note that in an attachment to a letter you addressed to Senator Cranston on March 17 you identified ten projects in your revalidation program that were questioned by the Inspector General. Can you identify for the Committee what his questions are and what criteria he utilized? Are there other projects that the Inspector General is questioning at this time? If so, please specify.

Answer. The attached list of major construction audit projects identifies the projects referred to in the letter to Senator Cranston.

Seven of the ten projects included in the Administrator's Revalidation Program that are indicated as questioned by the Office of Inspector General have not been finally reported on. Six of the projects are included in draft audit reports which

have been submitted to appropriate VA program personnel for comment. The seventh project, Minneapolis Medical Center has not reached the draft report state, and only preliminary observations have been prepared. Several other medical centers are currently being reviewed as part of the OIG's normal cycle.

Reviews at two of these medical centers, i.e., VAMC, Muskogee and VAMC, Dallas were discussed at recent congressional hearings. On completion of the reviews, and discussions of audit findings with program personnel, final reports will be issued. It is premature to indicate that projects have been questioned prior to issuance of final audit reports.

The audit approach followed in developing audit recommendations included a review of project justification data, including patient workload data and established Agency space criteria. When projects were not justified based on data maintained and provided by program personnel the projects were questioned.

SUMMARY OF CONSTRUCTION PROJECT REVIEWS
REPORTED ON DURING THE SIX-MONTH PERIOD ENDING MARCH 1982

Construction Planning Project

<u>Facility</u>	<u>Proposed Construction</u>	<u>Cost (Millions)</u>	<u>Finding</u>
● <u>Hines, IL</u>	Supply Depot Warehouse Expansion Project <u>Warehouse/Service Building Construction Project</u>	\$ 9.0 <u>11.0</u>	DMS did not concur will be placed in resolution process
*Existing facility space can be used to accommodate space requirements if scope of proposed project is reduced to renovation. A new warehouse is needed.			
● <u>Sioux Falls, SD</u> (Draft Report)	<u>Ambulatory Care and Clinical Addition</u>	12.0 <u>18.0</u>	
*Projected increases in inpatient and outpatient workload have not materialized. Existing space can accommodate present and projected space needs.			
● <u>Hot Springs, SD</u> (Draft Report)	<u>Clinical Addition</u>	13.0	
*Alternatives to new construction not considered. Renovation and realignment of present space will meet Center's current and future needs.			
● <u>Buffalo, NY</u> (Draft Report)	<u>Research and Education Building</u>	27.3	
*Scope of project should be reduced from 69,290 net square feet (NSF) to 21,232 net square feet (NSF). Existing space is presently underutilized.			
● <u>Beckley, WV</u> (Draft Report)	<u>Clinical Addition and Renovation</u>	25.0	
*Project not fully justified based upon workload and existence of adequate space. Scope should be reduced 13,351 NSF of new construction and 13,225 NSF of new construction and 13,225 NSF of renovated space.			
● <u>Fayetteville, NC</u> (Draft Report)	<u>Clinical Addition</u>	30.0	
*Project should be reduced by 8,732 NSF of new space because projected patient workload and space needs are overstated.			

* Indicates construction projects identified to Senator Cranston in letter of March 17, 1982.

SUMMARY OF CONSTRUCTION PROJECT REVIEWS

<u>Construction Planning Project</u>	<u>Proposed Construction</u>	<u>Cost (Millions)</u>	<u>Funding</u>
• Minneapolis, MN (Draft Report) <i>Project is under development</i> Renovation alternatives should be considered to more effectively utilize existing medical center facilities.	Replacement Hospital	\$21.3	
• Omaha, NE (Draft Report) Projected outpatient workload cannot reasonably be expected to materialize. Scope of new construction should be reduced from 72,000 NSF to 22,105 NSF.	Outpatient Addition	24.0	

• Indicates construction projects identified to Senator Cranston in letter of March 17, 1982.

BEST COPY AVAILABLE

Domiciliary Projects

<u>Facility</u>	<u>VACO Proposed New Construction</u>	<u>OIG Proposed Costs (Renovation)</u>	<u>OIG Proposed No. Beds (Renovation)</u>
Beth, NY	\$10.8 Million - 208 Beds	\$ 6.7 Million	210
or Renovation	13.8 Million - 270 Beds	11.5 Million	395
Hampton, VA	11.1 Million - 200 Beds	5.2 Million	240
or Renovation	24.3 Million - 287 Beds	14.4 Million	472
Leavenworth, KA	10.4 Million - 208 Beds	9.9 Million	775
White City, OR	25 Million - 200 Beds	None (No Major Renovation Recommended)	1,040
Prescott, AZ	10.8 Million - 200 Beds	5.2 Million	190
Temple, TX	11.5 Million - 200 Beds	10.8 Million	528
Mountain Home, TN	13.7 Million - 208 Beds	(None; No Major Renovation Recommended)	646
Hot Springs, SD	27 Million - 200 Beds	6.7 Million	485

Domiciliary Projects were questioned for the following reasons:

- *Renovation of existing space is less costly than new construction and will provide more beds.
- *Justification of need of one 200-bed Domiciliary in each Medical District is not supported by demographic data.
- *Current construction space criteria exceeds criteria for health care modalities.
- *Mission of Domiciliary Program needs to be defined - Residential Care Program versus Rehabilitation Medical Program.

- * Indicates construction projects identified to Senator Cranston in letter of March 17, 1982.

BEST COPY AVAILABLE

SUMMARY OF CONSTRUCTION PROJECT REVIEWS

<u>Construction Project Reviewed During Facility Audit</u>		
<u>Facility</u>	<u>Proposed Construction</u>	<u>Cost (Millions)</u>
<u>VAMC Battle Creek, MI</u>	<u>Addition of Administration Building</u>	<u>\$ 3.1</u>
oBuilding not justified based upon available underutilized space and declining workload.		
<u>VAMC Marion, IL</u>	<u>Ambulatory Care Addition</u>	<u>11.6</u>
oProjected increases in outpatient workload has not materialized-underutilized space was also available to meet current and future needs.		
<u>VAMC Perry Point, MD</u>	<u>New Clinical/Administration Bldg.</u>	<u>1.6</u>
oNo master space plan. Building not justified due to availability of underutilized space.		
<u>VAMC Allen Park, MI</u>	<u>Renovation & Expansion of Laboratory</u>	<u>1.8</u>
oMaster space plan had not been completed-space need for center not fully identified or justified.		
<u>VAMC San Diego, CA</u>	<u>Renovation & Expansion of Supply Warehouse</u>	<u>3.3</u>
oSpace needs changes due to change in mix of patients. Adequate space exists at facility for less costly alternatives.		

BEST COPY AVAILABLE

Question 5. Mr. Nimmo, on page 23-2 of Volume IV of the VA's medical construction and leasing authorization for fiscal year 1982, you indicate that Congress has previously approved an outpatient addition at the Marion, Illinois, VA Medical center in the amount of \$11.4 million. Can you please explain to us what has happened to this project?

Answer. Because of the concern expressed by the Inspector General and others, the Chief Medical Director withdrew the project until workload data and construction requirements could be examined. A study of the space needs at VAMC, Marion, Illinois, is being conducted and future construction will be programmed as indicated by this study. The VA's funding request for the Marion outpatient addition was eliminated in the fiscal year 1982 budget.

Question 6. In the list of the ten most urgently needed projects submitted in June of 1981, there is a project at the Aspinwall Division of the Pittsburgh VA Medical Center. In your authorization request for fiscal year 1983, there is an outpatient addition request for the University Drive Division of the Pittsburgh VA Medical Center in the amount of \$25,200,000. Please explain the relationship of the latter to the one in your listing of the ten most urgently needed projects.

Answer. The VA Medical Center Pittsburgh (UD) has two separate divisions which are located eight miles apart. The Outpatient Addition project which is included in the fiscal year 1983 budget will make substantial improvements of the Oakland Division. The vast majority of the Medical Centers' outpatient workload is met at this division.

The project identified on the list of ten in our Five Year Medical Facility Construction Plan is for the Aspinwall Division which was constructed in 1925 and primarily meets the Medical Center's long term care requirements.

Question 7. On page 24-4 of Volume IV of your budget request, you list for the VA Medical Center in Chillicothe, Ohio, the modernization of buildings 24, 31, and 35 at an estimated cost of \$16.4 million with a fiscal year 1983 authorization request at \$2.7 million. Previously, this project was authorized at a level of \$13.7 million. Will you please explain to us what the additional \$2.7 million requirement includes.

Answer. Additional funds in the amount of \$2.7 million were requested for the modernization of certain buildings at VAMC Chillicothe, Ohio, to allow for escalation costs created by the two-year deferral of the construction award.

Question 8. Can you please explain the policy on the replacement of domiciliaries? We note that two of these domiciliaries, Leavenworth, Kansas, and Prescott, Arizona, which are in bad need of replacement, are now placed in a deferred status.

Answer. We are currently assessing the future of the domiciliary program and direction determined in this review will update our policy on replacement domiciliaries and contribute to the revalidation of the planned construction projects at Leavenworth and Prescott.

Question 9. The Committee notes that there are no new requests for authorizations for leases in fiscal year 1983. Does this mean that you currently operate at the optimum number of outpatient clinics?

Answer. No. It only means we have not asked the Committee to authorize prospect size leases in fiscal year 1983 that cost more than \$500,000 net rent per year. Smaller outpatient clinics do not require Committee authorization.

Question 10. You indicate that the revalidation review for all potential fiscal year 1984 projects is to be completed in time for final review and decision on the Agency's fiscal year 1984 construction budget request. You don't have too much time before you begin your initial review and negotiations with OMB. I would, therefore, assume that revalidation teams have started their review. My question is what new criteria will the teams be using in conducting the review? Have you already published new guidelines which are being used by those involved in the review process?

Answer. The VA's six revalidation teams formally began their revalidation work on March 25, 1982, when each team was provided with a list of projects in their assigned Medical Region to be reviewed for potential fiscal year 1984 budget consideration. The teams also were provided with a schedule for revalidation work which entailed completion of the Central Office revalidation phase by April 30. Onsite reviews of projects are to be completed in May and June and final written recommendations for each project submitted for discussion to the Facility Planning and Construction Revalidation Steering Committee. As the teams complete the revalidation reports, the Steering Committee will review them, and based on this review and Department of Medicine and Surgery guidance on the medical program priority of these projects, finalize the fiscal year 1984 Major Construction budget recommendations to the Administrator.

Four memos are attached which provide the guidelines and criteria provided to revalidation teams for the review process.

VETERANS' ADMINISTRATION,
March 17, 1982.

To: FPAC Revalidation Steering Committee and fiscal year 1984 revalidation team members.

Subject: Revalidation procedures for central office review of fiscal year 1984 major construction projects.

1. A Central Office review of the projects on the fiscal year 1984 revalidation list is the first step in the revalidation process. Only those projects on the list which entail direct patient safety such as electrical deficiency corrections, fire and safety improvements, and seismic strengthening will be excluded from the revalidation process. The Office of Construction is reviewing these projects separately and will provide justification as to their life/safety necessity.

2. For each project assigned to it, each revalidation team shall review the project against a checklist of basic revalidation requirements. If deemed appropriate to a particular project, each team should evolve additional revalidation criteria as necessary.

3. The basic revalidation requirements for all Central Office fiscal year 1984 reviews shall include the following:

a. A review of the project development schedule to determine if the project can realistically be expected to be ready for fiscal year 1984 construction funding consideration. If full team consensus and concurrence by the Chief Medical Director are reached that a project absolutely will not be ready for consideration in the fiscal year 1984 budget, no further revalidation should be done on that project and a brief report written as to why the project will not be ready for fiscal year 1984 budget consideration;

b. A review of the veteran demographic data used to justify bed and workload projections, as appropriate;

c. A review and revalidation of the data package used by the Office of Construction for project development which DM&S will provide for each project on the revalidation list. Revalidation of this data package shall include bed projections, workload projections, staffing, space and functional deficiencies, and project scope. It is expected that for each project, the team will contact the affected VAMC to request verbal or written verification of the data package as well as determine the priority the VAMC places on the project. The team also shall contact the affected DM&S Regional Director to seek his or her professional opinion on the project need;

d. A review of the project's space requirements to determine consistency with H-08-9 (or other guidelines) and the data package;

e. A review of the statement of task given the A/E or the project authorization (for in-house) that was used to guide the development of requirements, technical assessment, concepts, and preliminary drawings;

f. A request of the VAMC to provide the team with the current station space survey and marked-up "as built" drawings (to include, if possible, current and imminent construction) as applicable to the project being revalidated. The team will use these space surveys and "as built" drawings to assist in verifying space and functional deficiencies;

g. A review of the concepts or preliminaries if available, and associated cost information to ensure consistency with the data package and scope and to determine responsiveness to identified space, functional or technical deficiencies;

h. A review of the project submission and cost limit notification (if available) for each project; and

i. A review of the proposed project in the context of the facility's five-year construction plan to ensure proper coordination with future planned projects. This review also should include an assessment of the coordination of the project with minor construction/minor miscellaneous and NRM projects scheduled by the station.

4. As part of the revalidation process, each team also should review each project from the broader perspective of:

The VAMC's mission (does DM&S still feel that the project is applicable to the VAMC's mission? Are changes in the VAMC's mission indicated by VAMC officials, the Regional Director or in the Five-Year Facility Plan?) It is important that as the teams focus on the applicability of projects to mission accomplishment, they focus to the extent possible on future mission. As projected VAMC mission statements are not yet available through MEDIPP, the teams should seek guidance from the Department of Medicine and Surgery;

The impact on outyear VAMC operating costs (e.g., will the project add or reduce operating cost and staffing needs);

The age of the VAMC facility area for which the project is scheduled (e.g., is the area scheduled for additional construction one in which recent replacement or extensive renovation work has been preformed. If so, why is this additional major construction needed?);

The applicability of the space criteria and construction standards used to the particular VAMC's needs and mission (e.g., space planned vs. unassigned space, if any, at the VAMC). Also, does the team have any general concerns that the project, as planned, includes construction requirements in excess of project need or entails questionable building costs?;

If the project will result in vacating existing VAMC space, what does the VAMC plan to backfill in that area;

The availability of state or community health resources which, in keeping with eligibility, policy, and law, impact on the need for the project; and

Common sense concerns which team members might have with respect to a particular project. (Most team members will have a Regional or Medical District perspective and the project need should be evaluated in that context as well.)

WILLIAM F. SULLIVAN,

Associate Deputy Administrator for Logistics.

VETERANS' ADMINISTRATION,

April 6, 1982.

To: Revalidation team members.

Subject: Use of current models and methodologies and new criteria in the fiscal year 1984 revalidation process.

1. This memo reiterates and emphasizes that your revalidation work on potential fiscal year 1984 projects is to be based on the most current data, models, and methodologies available to the Agency.

2. For your reference, the following reflects recent refinements in or new criteria available to the Agency's planning and construction program. Please ensure that your revalidation reflects these current improvements to the extent possible given the stage of design of each project being revalidated.

ELECTRICAL SYSTEMS DESIGN CRITERIA

New design criteria for the sizing of electrical facilities at VA facilities has just been finalized by the Office of Construction which will reduce the incorporation of costly and inefficient unused electrical capacity. This new criteria is ready for immediate application.

NURSING HOME CARE DESIGN CRITERIA

The Nursing Home Care Cost Reduction Task Force has recently implemented cost reduction elements which will result in an estimated cost savings on a 120-bed NHCU of \$1.5 million. Wherever possible, these cost reduction features should be incorporated into potential fiscal year 1984 NHCU projects.

MORE ACCURATE WORKLOAD PROJECTION MODELS

In the last years, Agency planners have developed more sophisticated workload projection models which should be used by the Revalidation Teams. Examples are as follows:

VA/GAO hospital bed sizing model

This model, implemented in 1980, has been made sensitive to the changing age mix and veteran migration patterns. The acute bed sizing portion of this model also is now linked to community hospital length of stay statistics and the results of the Multi-Level Care Surveys have been incorporated into the model. Further, each team is advised that on May 20, 1982, an estimate based on an 8% sample of the 1980 census will be available that DM&S plans to incorporate in the VA/GAO model which might result in more accurate projections.

Outpatient projection model

This model was improved in late 1979 to be more sensitive to veteran population and age distribution.

Nursing home and domiciliary bed requirements models

DM&S has recently updated and refined its HHC bed model and developed a new model for determining dom bed needs. Implementation of these models is dependent

on the Administrator's guidance. At the request of Budget Service, DM&S will also provide Revalidation Teams information on the availability of VA-supported State Homes for those states in which NHC projects are being revalidated as well as data on VA use of these State Homes.

NEW DEMOGRAPHIC DATA BASES

Revalidation Teams have available to them new demographic inputs which provide a check on the accuracy of Agency projections based on 1970 census data. For example, the new MEDIPP Baseline Submissions, submitted by the Medical Districts in January 1982, provide up-to-date hospital specific data on each facility's programs, deficiencies, and veteran demand and demography for the VAMC area. DM&S also will be generating new county specific data based on the first sample of the 1980 veteran census data which will be provided to the VA in the near future.

STAFFING STANDARDS

In 1981, the CMD established a Staffing Standards Task Force and institute the Management Systems Service (131) in DM&S to establish staffing standards for each medical program area. Revalidation Teams should request assistance from the Assistant Chief Medical Director for Administration for revalidation of staffing standards based on the work of the task force. Also, the Teams could review a recently completed facility for a comparison between staffing projected during the planning phase and actual staffing currently on the payroll.

REVISIONS IN SPACE PLANNING CRITERIA

In the last three years (1979-1981), there have been 22 revisions approved by the Administrator in the VA's space planning criteria in 22 different functional areas. Projects being revalidated should reflect this new space planning criteria as appropriate. Areas affected include SPA, Nursing Home Care, ICU, Dietetics, Education, Cardiology Labs., etc.

VAMC MISSION STATEMENTS

While the the future mission statements for VAMCS are not yet available through the MEDIPP Process, Revalidation Teams should seek guidance from DM&S on whether any changes are expected in a VAMC's future mission which would impact on the project being revalidated.

ADMINISTRATOR'S GUIDANCE

An update of the 1978 Guidance is being prepared for the Administrator. Based on this updated policy options reports, the Administrator will issue policy guidance which will be provided to the Revalidation Teams as soon as it is finalized. Included in the guidance will be new policies for the VA's domiciliary and nursing home care programs.

WILLIAM F. SULLIVAN,
Associate Deputy Administrator
for Logistics and Vice Chairman for FPACC.

COST REDUCTION ITEMS FOR IMMEDIATE IMPLEMENTATION, NURSING CARE HOMES

1. Omit provisions for vertical expansion. Provide capability only when specifically justified.
2. Adopt Modular Design Concept for Nursing Wings.
 - (a) Eliminate 4-bed patient rooms.
 - (b) Use 7'-0" length patient beds.
 - (c) Reduce single patient room by 10 NSF.
3. Use the least expensive structural system compatible with the configuration of the building and the site. Consider wall bearing with roof joists.
4. Toilets and bathrooms.
 - (a) Eliminate all showers and tubs in all private or shared bathrooms, connected to bedrooms.
 - (b) Eliminate urinal in congregate bath.
 - (c) Provide two full bathrooms per 60-bed unit to contain a tub, lavatory, and water closet in lieu of any bathrooms connected to a bedroom.
 - (d) Configure bed structure for 60 beds with: six single bedrooms; two singles with private toilet; and four singles with shared toilets for each pair of rooms; and with

27 two-bed rooms, 26 will have a shared toilet for each pair of rooms; one will have a private toilet.

5. Reduce dining room by 38 percent. Meals will be served in two sittings rather than one.

6. Reduce recreation room space by 35 percent. The recreation and dining areas will be adjacent so that the dining room may be used for recreational activities when meals are not being served.

7. In lieu of male and female toilets in lobby area for visitors, use one unisex with laboratory and water closet. Use similar single unisex toilet for dining room.

8. Reduce social work office from 120 NSF to 100 NSF.

9. Reduce maximum space for rehab/rec therapists from 200 NSF to 150 NSF.

10. Eliminate razor blade receptacles in toilets.

11. Use 3'-8" x 6'-8" doors in lieu of 3'-10" x 7'-0" in patient rooms.

12. Do not design exterior balconies at bedrooms.

13. All ceilings 8'-0" in lieu of 9'-0".

14. When station's trash disposal uses dumpster system, eliminate trash room.

15. Use design discretion to eliminate or reduce skylights.

16. Use design discretion to reduce glass areas.

17. Do not provide revolving doors.

18. Reduce stair landings to 3'-8" deep.

19. Do not provide connecting corridors or tunnels unless specifically justified.

20. Reduce capacity of hot water generator and storage tank consistent with data obtained in past and on-going field testing conducted by Mechanical Engineering Service.

21. Reduce quantity of electrical convenience receptacles in patient rooms.

22. In home-run conduit only, permit six electrical circuits.

23. Reduce electrical, signal, and telephone closet depth to 12".

24. Select least expensive method to obtain reduced lighting levels for appropriate areas.

25. Where an emergency generator is necessary, locate it outside of the building structure.

26. Provide emergency generator only when required by code, seismic or other justifiable need which cannot be satisfied in a less expensive manner.

27. Use 120/208 main distribution voltage in lieu of 277/480.

28. Minimum conduit size will be 1/2" diameter.

29. Omit TV antenna outlets in all patient rooms. TV outlets shall be installed in patients' lounges and recreation rooms. In patient bedrooms, TV's may be plugged into regular electrical outlets, using portable antennae.

30. Use conventional standard lavatory with gooseneck spout and wrist operated faucets for wheelchair access.

31. Delete ceramic tile in drinking fountain alcove. Substitute heavy duty vinyl wall covering instead.

32. Delete requirement for non-skid ceramic/quarry tile in toilets, utility rooms and other areas not subject to standing water and/or grease. Provide non-skid surface in bath/shower areas and food preparation/dishwashing areas.

33. Quiet Rooms:

(a) Provide one Quiet Room of 180 NSF in a single-level 120-Bed NHCU.

(b) Provide one Quiet Room of 180 NSF in a multi-level, 120-Bed NHCU on each level.

(c) Provide one Quiet Room of 180 NSF in a 60-Bed NHCU.

34. Delete drywall protection of roof structure.

35. Reduce landscaping by 50%.

VETERANS' ADMINISTRATION,
March 17, 1982.

To: FPAC Revalidation Steering Committee and fiscal year 1984 revalidation team members.

Subject: Fiscal year 1984 construction revalidation format.

THREE-STEP REVALIDATION FORMAT

1. My memo to you of February 26, 1982, (copy attached) set forth a three-step format for the Administrator's construction program review to revalidate projects potentially eligible for consideration for fiscal year 1984 Construction, Major funding.

2. The three-step revalidation format for each project entails a Central Office review, an onsite visit if closer review is determined necessary, and based on the results of the two preceding reviews, selected projects may require a more in-depth onsite investigation of longer duration similar to a full-scale project audit. If it is determined that a project will require a full-scale audit, it is possible that the project may not be ready for fiscal year 1984 budget consideration. Should this be the case, the revalidation team (see 4.) should complete work on other higher priority projects prior to conducting a lengthy, onsite audit of a project which clearly will not be ready for the fiscal year 1984 budget.

LIST OF FISCAL YEAR 1984 REVALIDATION PROJECTS

3. Attached is a list of those major construction projects currently scheduled to have both their preliminary design and cost target completed by October 1982 and hence, those available for possible inclusion in the fiscal year 1984 budget. While there may be some revision in this list based on unforeseen problems, this list provides the best estimate at this time of those potential fiscal year 1984 projects which must be revalidated.

REVALIDATION TEAMS

4. Potential fiscal year 1984 projects will be divided into six (6) groups by Region and assigned to one of six (6) revalidation teams. As some teams have more projects to revalidate than others, it is recognized that such teams may need additional staff.

5. Each of the six revalidation teams is composed of representatives selected by the head of each of the following Departments or Staff offices:

The Department of Medicine & Surgery

The Office of Construction

The Office of Budget & Finance

6. While team membership may vary or be expanded depending on the particular project or project aspect being revalidated, the following lists the core membership for each of the six revalidation teams:

TEAM I—MEDICAL DISTRICT 1 (NORTHEASTERN)

Tom Breedlove, (10A4B) x 5361-5362.

Albert L. Reese, (086A) x 3581.

James I. Gracyalny, (041B2) x 3476-3979.

TEAM II—MEDICAL DISTRICT 2 (MID-ATLANTIC)

Burton L. Ziskind, (10A4B2) x 5361.

Edward P. (Ted) Demarest, (086B) x 3581.

Michael L. Young, (041C2) x 3709-3476.

TEAM III—MEDICAL DISTRICT 3 (SOUTHEASTERN)

Larry A. Wallace, (10A4B3) x 5363.

William B. (Brooks) Martin, (086C) x 3823.

Jerry A. Unklesbee, (041C2) x 3709-3476.

TEAM IV—MEDICAL DISTRICT 4 (GREAT LAKES)

James H. Korjus, (10A4B4) x 5363.

Leo E. Estrella, (086D) x 2775.

Pamela J. Rinehart-Ganous, (041C2) x 3709-3476.

TEAM V—MEDICAL DISTRICT 5 (MID-WESTERN)

Henry A. Garbelman, (10A4B6) x 5026.

J. R. (Russ) Daughtry, (086E) x 2823.

Edgar C. (Tony) Peoples, (041C) x 2370-3418.

TEAM VI—MEDICAL DISTRICT 6 (WESTERN)

Steven Kleinglass, (10A4B) x 5361-5362.

Bruce A. Plecinski, (086F) x 3681.

Clarence E. Meade, (041A) x 3464-3839.

7. In addition to these team members, support will be provided to each team as needed from Departments and Staff Offices. For instance, the Office of Program

Analysis and Development (DM&S) and the Office of Reports and Statistics will provide staff support to each team to validate workload requirements. The Office of Construction will provide Health Care Facilities Specialists, architects, engineers, and estimators to each team, as needed, to assist the team's revalidation effort.

TEAM LEADERS

8. The team leader for each team will be appointed by the Facility Planning and Construction Committee.

9. Each team will determine the schedule for revalidation of the project assigned to that team and the order of priority in which each project will be revalidated. The team leader will be responsible for reaching team consensus on the revalidation schedule for his or her team and ensuring that the schedule is followed.

10. The team leader will also be responsible for reaching team consensus, if possible, and justifying the team's decision on whether each project reviewed in the Central Office revalidation phase:

(a) Either needs to further revalidation and is justified as scoped for possible fiscal year 1984 funding; or

(b) Needs to be further inspected onsite at the second stage of the revalidation process.

REVALIDATION STEERING COMMITTEE

11. The following members of the Facility Planning and Construction Committee (FPACC) will serve as the steering committee for the fiscal year 1984 project revalidation process including both the Central Office revalidation and the onside revalidation review:

Mr. Charles T. Hagel, Deputy Administrator (001).

Mr. William F. Sullivan, Associate Deputy Administrator for Logistics (005).

Mr. O. Fielding Cochran, Associate Deputy Administrator for Congressional & Public Affairs (002).

Dr. Donald L. Custis, Chief Medical Director (10).

Mr. William A. Salmond, Assistant Deputy Administrator for Construction (08).

Mr. Conrad R. Hoffman, Assistant Deputy Administrator for Budget & Finance (04).

Mr. John P. Murphy, General Counsel (02).

Mr. Joseph Mancias, Jr., Assistant Deputy Administrator for Public & Consumer Affairs (06).

Mr. Robert W. Schultz, Assistant Deputy Administrator for Reports & Statistics (70).

Mr. Gregory McGowan, Executive Asst. to Deputy Administrator (001A).

Dr. O. David West, Executive Director of FPACC.

12. As the Revalidation Steering Committee, this group will guide the revalidation process, resolve any problems which arise, and review and in consultation with the Administrator (00) make final decisions on the specific project recommendations of each revalidation team.

13. If the Revalidation Steering Committee cannot reach consensus on a specific project recommendation, the project will be forwarded to the Administrator for resolve.

14. The Revalidation Steering Committee will ultimately report to the Administrator (00) on the full results of the revalidation process.

15. For those projects revalidated and found eligible for fiscal year 1984 construction funding consideration, the Chief Medical Director will provide to the Administrator a list of those projects in the order of priority assigned to them by the Department of Medicine and Surgery.

REVALIDATION COORDINATOR

16. The overall coordinator for the fiscal year 1984 revalidation review will be William F. Sullivan, Associate Deputy Administrator for Logistics (005) who will report to the Revalidation Steering Committee.

17. Each team leader shall report to Mr. Sullivan through Dr. David West, Executive Director of FPACC, at least once a week on the progress of his/her team's revalidation review and identify problems which may need resolve by the Revalidation Steering Committee.

18. As each team completes the Central Office revalidation review of a particular project, the team leader shall report to the Associate Deputy Administrator for Lo-

gistics through Dr. West the recommendations of the team on that particular project for forwarding to the Steering Committee.

WRITTEN REPORTS

19. Each team will be responsible for producing a written final report for each of the projects it revalidates.

20. This report will detail the results of the team's revalidation for each project, including the team's recommendations on the project and the team's justification for these recommendations. The report will also contain any dissenting views by team members.

21. A basic format for the written reports will be provided to each team.

22. If a team decides that a project is fully validated at the completion of the Central Office review stage and that the project does not require further onsite inspection, the team will issue a final report on that project as soon after Central Office review as possible and submit it to the FPAC Steering Committee. This report will include the team's justification for determining that a further onsite investigation is not needed.

23. Brief interim reports will be issued for those projects which the teams determine will require onsite visit. These reports will be issued at the conclusion of the Central Office review and briefly state the team's initial findings and explain the need for the further onsite examination. These reports also will be submitted to the FPAC Revalidation Steering Committee.

SCHEDULE

24. The revalidation results for all potential fiscal year 1984 projects are to be completed in time for review and decision on the Agency's fiscal year 1984 budget request. To accomplish this goal, the Central Office project reviews should be completed by April 30. Onsite reviews will take place in May and June and final reports written for each project and submitted to the FPAC Revalidation Steering Committee. In July and August the Steering Committee will review the team reports and based on this review, finalize fiscal year 1984 Major Construction budget recommendations to the Administrator.

25. Team leaders experiencing problems in meeting this revalidation schedule will immediately report such problems to the Executive Director of FPACC.

WILLIAM F. SULLIVAN,

Associate Deputy Administrator for Logistics.

Question 11. The A.P. article quoted you as saying that VA medical sites have always been selected on a political basis, and there has been little consideration of whether shifts in veteran populations would render them unneeded. Assuming the quotation is accurate, would you explain the nature of the political forces you believe to be involved in the selection process?

Answer. My reference to the role of politics in the VA's facility construction program recognizes that the environment in which the VA health care delivery system operates is one characterized by multiple internal and external forces which input into decision-making at all levels of the Agency. Our affiliated medical schools frequently express interest in expanded research programs and additional VA medical center space for research and educational activities which will result in improved levels of clinical care. Members of Congress appropriately take an active interest in VA medical facilities in their States. Citizen groups often take an active stance either for or against planned VA medical facility projects. Veterans service organizations reflect the interest of the veterans they represent in particular VA medical program areas.

Our planning process must recognize that there are increasing demands being placed on the system, while at the same time we may face a budgetary future of diminished construction resources. The need to be able to objectively prioritize and justify our construction projects, reduce our construction costs, and improve our planning process have never been greater.

Question 12A. Do you agree that affiliations with medical schools are beneficial to the Veterans Administration?

Answer. Yes.

Question 12B. Do they not enhance the quality of care provided our veterans?

Answer. They do.

Question 12C. What did you mean when you said the cost of affiliation is "tremendous"?

Answer. Because of the teaching requirements, affiliated hospitals require substantially greater space allocations than do non-affiliated hospitals. Further, educa-

tional, research and office space requirements for university faculty, students, and residents add measurably to our building costs.

For example, in the most recent Five Year Medical Facility Construction Plan, a Research Building for VAMC Ann Arbor is estimated to cost \$25 million; a clinical and educational improvements project at VAMC Boston is estimated to cost \$53 million; and at VAMC, Omaha a single education addition is estimated to cost \$4 million. There are many other such projects in the Five Year Plan as well as a number of such projects provided under Minor Construction.

Question 13. Do you believe the law should be changed in reference to the medical care of veterans age 65 or older? Do you believe a veteran should be presumed to be totally and permanently disabled for pension purposes at age 65? Does the nation have any obligation to provide medical benefits and services to veterans with non-service-connected disabilities.

Answer. I believe the public should be aware of the fiscal implications of the current legislative requirements for providing medical services to veterans age 65 and older without regard to financial status, health or hospitalization insurance coverage or social security coverage. I am concerned that an absence of public awareness and realistic planning could lead to an overloading of the VA health care system and adversely affect our ability to provide to service-connected and eligible non-service-connected veterans the high quality health care to which we are committed.

Question 14. WE have been hearing a lot of talk that the VA does not view the list of ten hospitals in most urgent need of construction, replacement, or modernization as a list in order of priority of need. How do you view this list, particularly in light of section 5007 of title 38, United States Code?

Answer. In reviewing this section of the law, it is clear that the list is required to be in priority order. Much uncertainty has arisen recently because of the difficulty of prioritizing a group of medical centers which all have serious deficiencies, and because the complexity of various projects results in a disparity in the length of time required for their development. Our goal in developing new construction criteria is to be able to logically prioritize major health care construction projects.

Question 15. In their view, GAO found that you frequently changed the scope of design and construction contracts. For the ten design contracts GAO reviewed, you made 198 changes, increasing the projects' cost by 18.8 percent and causing the contract completion dates to slip an average of 9.6 months for nine of the contracts. The 11 construction contracts associated with these projects had 1,847 changes, which added about seven percent to the total contract cost. Do you consider this amount of change to your design and construction contracts reasonable? What internal procedures do you follow to assure that these changes are kept to a minimum?

Answer. The VA feels that corrective action has already been taken to alleviate the kinds of problems cited in the report concerning programmatic changes during design and construction. The principal corrective action has been the institution, since the project in the study were designed, of the Advance Planning Fund (APF). By using APF funding to develop projects through preliminary planning, VA can expect, and in fact has already experienced, earlier resolution of programmatic needs. Flowing from the APF process is an in-house operating instruction that no programmatic changes during working drawing and construction will be made without the Administrator's approval. Of course, Congress will be advised if programmatic changes revise the scope of the project or exceed the Administrator's reprogramming authority.

VA wishes to point out that, in its view, the GAO analysis is somewhat distorted in that one very large programmatic change in the amount of over \$1.5 million made to the Los Angeles project during construction with the full advice and consent of the Congress, completely skews the analysis. This programmatic change distorts the total contingency percentage in a way that is not at all reflective of normal VA contingency experience in the Major program. Current studies and analyses indicate that Major projects are being accomplished well within long established contingency allowances of 5 percent for new work and 7½ percent for alteration work.

Question 16. In the cost estimates for your major construction projects, you included a portion of the total cost for inflation. In addition, you calculate a "contingency" amount.

A. What percent of each project's cost estimate is for "contingencies"?

B. What "contingencies" generally arise on your projects for which you don't request additional appropriations?

C. What is the percentage based on; i.e., total project cost, design costs, or construction costs?

D. During the life of a project, how often does the contingency estimate change? Why?

Answer. A. A 5 percent contingency is used for new construction work while 7½ percent is used for renovation work. If a project is a combination of new and renovation construction, and proportional average of 5 percent and 7½ percent is used.

B. Additional appropriations are not requested for contingencies that fall within the allowances described above. These contingencies cover changes to the construction contract classified in broad categories for unforeseen or unexpected conditions as, program changes, changes caused by design errors or omissions, and changes from differing site conditions.

C. The contingency percent is based on a percentage of the construction costs.

D. Generally, the amount of the contingency allowance changes only once during the life of a project. Using the same percentages described above, the contingency amount is recalculated prior to construction contract award based on the lowest acceptable bid. Excess funds are placed in a working reserve account and reported in the budget document. Should a project require contingencies above the amount allowed, a cost increase must be approved by the Administrator or the Congress depending on the amount. (Congressional notification occurs if the increase is 10 percent or \$250,000, whichever is less.)

Question 17. One of the principal bases to your space planning system seems to be the Space and Functional Deficiency Identification System, which matches your general space criteria to actual square footage in the facilities. The system also includes data on space needs because of affiliations, the functional efficiency of the facility, and deficiencies identified by external reviews, such as the Joint Commission on the Accreditation of Hospitals.

A. How were your criteria established?

B. Were any experts outside of VA relied on?

C. How do your standards compare to those for non-Federal hospitals?

D. How accurate are the data in the SFDI system?

E. With the almost constant renovation and alterations that take place at each medical center, how do you keep track of the amount of space actually being used by the various services at a hospital?

F. Does this system assign any priority to the deficiencies? For example, does a space shortage in the surgical suite have the same weight as a space shortage in the hospital director's office?

Answer. A. The VA has developed space planning criteria for each functional area of a VA medical center (e.g., nursing units, surgical suites, radiology, etc.). These criteria are contained in VA Handbook H-08-9—*Planning Criteria for VA Facilities*. Space planning criteria for a functional area are developed by interdepartmental teams using approved protocols which incorporate thorough investigation and analysis of function and space requirements. These criteria are the basis for facility planning, project development and facility evaluation through the SFDI System. New criteria are developed and existing criteria are revised on a continuing basis to reflect current technology and practice in the delivery of health care.

B. In developing space planning criteria, the VA utilizes the best professional expertise available throughout the government and the private sector. Typically, research and development activities associated with space planning criteria will include a review of literature to obtain a broad spectrum of published perspectives from all sectors. In addition, these studies will include on-site visits to VA, other governmental, and private sector facilities.

In addition to activities associated with a specific functional set of criteria, VA personnel participate in a large number of organizations and activities oriented to medical management and administration, specific programs of health care delivery, and facility designed and construction. These organizations provide forums for the exchange of ideas between participants representing all sectors and aspects of health care delivery.

C. There is no compilation of standards in the private sector comparable to the body of VA space planning criteria. Most private sector health care facility design criteria are developed and used on a project by project basis. In fact, VA criteria is widely used within the United States and in foreign countries as a resource for health care facility design. Informal feedback from private architects indicates that VA criteria works well in the private sector where needs are equivalent. Of course, there are many aspects of VA health care delivery that are unique and require different design considerations.

D. SFDI is an "umbrella" name for a complex information system which supports the VA's medical center facility planning and associated budget processes. As such it is composed of many integrated sub-systems supporting various phases of the

overall planning/budget process. SFDI is in the early stage of a long development process and the quality of the data reflects the extent of development of associated parts of the system.

There are five categories of data that comprise the SFDI data base. These include:

1. Medical Center Characteristics (size, complexity, mission, location, etc.).
2. Functional Evaluation (characteristics and functional deficiencies of wards and services).
3. Space Evaluation (in-use, required and planned changes to space).
4. Physical Plant Evaluation (characteristics and deficiencies in buildings and utility systems housing and supporting the health care activities).
5. Project Inventory (information on planned, funded and completed Non-Recurring Maintenance (NRM), Minor Miscellaneous, Minor, and Major projects).

SFDI was originally implemented as a manual system without any capability to update or maintain the information. Subsequently, work began on an ADP environmental that would provide for data validation and maintenance as well as support more sophisticated analyses and allow direct use by the many field and VACO users.

Available ADP resources were sufficient only to develop SFDI in phases. The first phase was completed in 1980 and included development of the overall data base and general system structure. The SFDI information was loaded into the system during this phase and is available in unvalidated form. The second phase currently underway includes developing the subsystems associated with the project inventory. These subsystems support medical center and district planning, NRM program management, annual construction budget information, and development of the Five Year Medical Facility Construction Plan. This phase will be completed in fiscal year 1984.

Work has begun on the space evaluation and physical plant evaluation subsystems. Work on the functional evaluation subsystem will be started in the future. At the present level of resources, the entire SFDI program will be operational in the late 1980's. The degree of accuracy of the various types of data is SFDI is of course dependent on completion of the various subsystems associated with that data.

E. Initially space information was obtained for SFDI from another VA computer system called the Medical Facility Planning System. However, this system was not originally designed for this function and the space data is difficult to use. We are implementing a new procedure to obtain space data directly from each medical center's individual Five Year Facility Plan. This will enable us to maintain data on in-use and required space for wards and services and relate this to planned space changes associated with the projects included in the plans.

As a result of the recent decision to decentralize ADP to the VA medical centers, we anticipate that we will be able to link to local space management systems as they are implemented. This will ultimately provide the most accurate source of in-use space data.

F. SEFI does not assign priorities to deficiencies. SFDI provides information on the relative severity of deficiencies for similar functions. This data, along with information on program priorities and agency and national policies enable professional health care managers to establish priorities. Priority decisions in a complex, dynamic environmental such as the VA's health care system can not be made automatically through the use of mathematical models. These priority decision can only be reached through the application of professional judgement weighting all appropriate factors.

Question 18. In your five-year plan for 1982-1986, you list nine nursing home projects for fiscal year 1982. All nine projects were funded in your fiscal year 1982 appropriation. The plan also lists eight nursing home projects for fiscal year 1983; however, only four (Boise, Hines, San Antonio and St. Louis) are in your fiscal year 1983 budget request.

A. Why were the other four (Lyons, Martienz, Northport and San Francisco) dropped?

B. What criteria did you use to decide which projects to support and which to drop?

C. Does this indicate that the goal for having 13,100 nursing home beds available in 1987 is not going to be met?

D. Do you plan to request funding for the remaining four in fiscal year 1984?

Answer. A-B The deferral was due to the fact that preliminary plans were not complete for these projects. The projects included in the budget have complete preliminary plans.

C. We expect to meet the goal of having 13,100 beds available in 1987.

D. These four projects are currently being reviewed for possible Fiscal year 1984 consideration. Because of site and other difficulties, however, relocation of the

planned Martinez and San Francisco Nursing Home Care Units to alternate Bay area locations may have to be considered.

FROM HON. JOHN PAUL HAMMERSCHMIDT TO ADMINISTRATOR NIMMO

Question 1. Why did you stop the construction project at Perry Point, Maryland? Was this the result of an Inspector General report?

Answer. In auditing the project at Perry Point which would have provided a new clinical and administration building, the IG identified aspects of the project which were not sufficiently justified. After careful evaluation of the IG's findings and consultations between DM&S and the Office of Construction, DM&S recommended the project be cancelled.

Question 2. The Veterans Administration is required by law to submit a list in priority order of at least ten most needed projects. Last year VA submitted such list with the Minneapolis project at the top. There was then a change in plans and Albuquerque is not at the top of the list. Does the submission of this list cause the Veterans Administration problems?

Answer. The submission of the list does not cause the VA any problems other than those associated with the difficult task of selecting and prioritizing the medical centers on the list. Albuquerque was included in the fiscal year 1983 budget request because the project had proceeded through project development to the extent that a cost estimate based on completed preliminary plans was available. Large complex projects such as these require varying lengths of time for development. The development of Minneapolis had not proceeded to the point that it could have been included in the budget. This was not a shift in priorities.

Question 3. I understand that you are taking a hard look at certain projects where perhaps workload projections for the future have come into question. Just what are you doing in this field?

Answer. Many of the projects that the VA is considering for construction funding in fiscal year 1984 and the outyears were placed in the pipeline some years ago. Planning is an evolutionary process and projects should be constantly reassessed as the process changes.

Since the time that the original proposals for many of these projects were submitted, Agency planners have developed more sophisticated workload projection models. For instance, the VA/GAO hospital bed sizing model implemented in 1980 has been made sensitive to the changing age mix and veteran migration patterns. The acute bed sizing portion of that model is also now linked to community hospital length of stay statistics. In addition, the VA's outpatient projection model was improved in late 1979 to be more sensitive to veteran population and age distribution. New demographic data bases are also available for use by the revalidation teams. The MEDIPP Baseline Submissions, submitted by the Medical Districts in January 1982, provide up-to-date hospital specific data on each facility's programs, deficiencies, and veteran demand and demography for each medical center's service area. Workload data is also being projected out to 1990, the VA's current projection year rather than the 1985 data base used as the planning base in prior years.

All of these new models and data bases will be used by the revalidation teams in their project reviews to ensure that each project is assessed on the latest and best planning data and techniques available to the Agency.

Question 4. How much longer is it going to take for you to complete your seismic construction program? How much has it cost thus far and what is going to be the total cost?

Answer. Since 1972, approximately \$334 million has been appropriated specifically for the correction of seismic deficiencies. During this period, funding has also been provided in other program categories where seismic corrections are a part of projects whose main thrust is to correct basic medical deficiencies. Examples of such projects in the fiscal year 1983 budget are the Albuquerque, NM, San Francisco, CA, and Birmingham, AL, modernizations which provide for alleviation of seismic problems at these facilities.

While funding to date has allowed the correction of nearly all high risk seismic deficiencies, we are examining our criteria for future seismic upgrading in the light of updated seismic codes and the protection of employees, as well as patients in lower risk areas. When these studies are completed and have been coordinated with OMB, we will be in a position to estimate the total funding and time required to bring us into full seismic compliance.

Question 5. Do you anticipate the cancellation of any major projects for 1984 or in the outyears even though your review is just beginning?

Answer. It is too early to determine if any proposed fiscal year 1984 or outyear construction projects will be cancelled as a result of the revalidation process. The revalidation of potential fiscal year 1984 projects is just nearing completion of the first stage of review and it will be several months before the full review is completed. It is not unusual, however, for several VA construction projects to be cancelled or redeveloped each year based on Department of Medicine and Surgery recommendations.

Question 6. I understand it takes a very long time to select architect-engineers. Do you have any suggestions as to how to reduce this time element while still assuring that you make good selections?

Answer. The A/E selection process is in keeping with PL 92-582 (Brooks Bill), which requires advertisement in the Commerce Business Daily. An intermediate screening is done of all eligible respondents with a minimum of three A/E's being interviewed before a selection is made. We have recently made an adjustment to the selection process that has reduced the time substantially, and we will continue to pursue further time reductions in our selection process.

Question 7. What is your method of assuring that the Department of Medicine & Surgery will have full input into your review of hospital construction projects and what is your method to assure that the Assistant Deputy Administrator for Construction has full input?

Answer. The establishment of the Facility Planning and Construction Committee (FPACC) within the VA does not reduce in significance the role of the Chief Medical Director in recommending health care policy to me nor affect the role of the Assistant Deputy Administrator for Construction in developing the appropriate construction mode to meet identified project needs.

FPACC is simply intended as a deliberative body composed of the Agency's top management to help generate ideas, review policy options and serve as a discussion forum for improvements in the Agency's facility planning and construction program. In the area of facility planning and construction, affected VA Departments and Staff Offices will continue to play the roles they always have, with FPACC providing the opportunity for creative discussion of the Agency's planning and construction program.

Throughout the development of the format for the construction program review, the Chief Medical Director's and the ADA for Construction's input and concurrence were obtained and staff from each of those organizations serve on the six revalidation teams currently reviewing potential fiscal year 1984 projects. The list of those projects to be revalidated for fiscal year 1984 budget consideration also was developed by the Department of Medicine and Surgery and the Office of Construction.

Question 8. When will the criteria to be used for your review of the construction program be finished and will you furnish the Committee copies of such criteria?

Answer. Each of the six VA teams revalidating projects for potential fiscal year 1984 budget consideration have been provided with guidelines to be used in their revalidation review process. Copies of those guidelines are attached.

Simultaneous with the revalidation process, the Department of Medicine & Surgery is currently updating the policy options to meet veteran health care needs that were last done in 1978. Once this report is completed in the next few weeks, it will be presented to the Administrator and the views and comments of FPACC sought. Based on briefings to the Administrator and the Administrator's discussions with the Agency's top management, the Administrator will issue updated policy guidance which will provide direction to our long-range planning for the VA's health care delivery system. This guidance also will be incorporated into the revalidation of fiscal year 1984 construction projects and provide direction to the MEDIPP process.

Beyond guiding the revalidation process and assisting the Administrator in updating the Agency's basic policy guidance, FPACC is charged with a third task which is to analyze the Agency's current facility planning and construction procedures and make recommendations, as appropriate, for improvements. The focus of this FPACC task is on the effectiveness of the operational aspects of the Agency's planning and construction programs and the appropriateness of the organizational structure for these functions.

While actual work on this phase of FPACC's work has yet to be formally instituted, many issues which will need to be addressed in this phase have been raised as a result of the revalidation process. Actual work on this "nuts and bolts" analysis will not be initiated until the new policy guidance has been issued. Once this guidance is issued, FPACC subworking groups will be assigned the task of evaluating perceived problems, deficiencies or inefficiencies in the Agency's planning process, prioritization criteria, and the cost, quality and timeliness of the Agency's construction program. Prior to recommending changes, improvements or refinements in these areas,

FPACC is to assess the current and potential impact of ongoing refinements such as SFDI, MEDIPP, improved data bases, etc., in addressing the problems identified.

The updated policy guidance, the FPACC analysis of current VA planning and construction procedures, new criteria being developed as part of the MEDIPP process and finalization of ongoing refinements in such areas as nursing home cost reductions and space planning criteria will all impact on the VA's future construction program. We will keep the Committee closely advised of our work in all of these areas.

VETERANS' ADMINISTRATION,
March 17, 1982.

To: FPAC Revalidation Steering Committee and fiscal year 1984 revalidation team members.

Subject: Revalidation procedures for central office review of fiscal year 1984 major construction projects.

1. A Central Office review of the projects on the fiscal year 1984 revalidation list is the first step in the revalidation process. Only those projects on the list which entail direct patient safety such as electrical deficiency corrections, fire and safety improvements, and seismic strengthening will be excluded from the revalidation process. The Office of Construction is reviewing these projects separately and will provide justification as to their life/safety necessity.

2. For each project assigned to it, each revalidation team shall review the project against a checklist of basic revalidation requirements. If deemed appropriate to a particular project, each team should evolve additional revalidation criteria as necessary.

3. The basic revalidation requirements for all Central Office fiscal year 1984 reviews shall include the following:

a. A review of the project development schedule to determine if the project can realistically be expected to be ready for fiscal year 1984 construction funding consideration. If full team consensus and concurrence by the Chief Medical Director are reached that a project absolutely will not be ready for consideration in the fiscal year 1984 budget, no further revalidation should be done on that project and a brief report written as to why the project will not be ready for fiscal year 1984 budget consideration;

b. A review of the veteran demographic data used to justify bed and workload projections, as appropriate;

c. A review and revalidation of the data package used by the Office of Construction for project development which DM&S will provide for each project on the revalidation list. Revalidation of this data package shall include bed projections, workload projections, staffing, space and functional deficiencies, and project scope. It is expected that for each project, the team will contact the affected VAMC to request verbal or written verification of the data package as well as determine the priority the VAMC places on the project. The team also shall contact the affected DM&S Regional Director to seek his or her professional opinion on the project need;

d. A review of the project's space requirements to determine consistency with H-08-9 (or other guidelines) and the data package;

e. A review of the statement of task given the A/E or the project authorization (for in-house) that was used to guide the development of requirements, technical assessment, concepts, and preliminary drawings;

f. A request of the VAMC to provide the team with the current station space survey and marked-up "as built" drawings (to include, if possible, current and imminent construction) as applicable to the project being revalidated. The team will use these space surveys and "as built" drawings to assist in verifying space and functional deficiencies;

g. A review of the concepts or preliminaries if available, and associated cost information to ensure consistency with the data package and scope and to determine responsiveness to identified space, functional or technical deficiencies;

h. A review of the project submission and cost limit notification (if available) for each project; and

i. A review of the proposed project in the context of the facility's five-year construction plan to ensure proper coordination with future planned projects. This review also should include an assessment of the coordination of the project with minor construction/minor miscellaneous and NRM projects scheduled by the station.

4. As part of the revalidation process, each team also should review each project from the broader perspective of:

The VAMC's mission (does DM&S still feel that the project is applicable to the VAMC's mission? Are changes in the VAMC's mission indicated by VAMC officials, the Regional Director or in the Five-Year Facility Plan?) It is important that as the teams focus on the applicability of projects to mission accomplishment, they focus to the extent possible on future mission. As projected VAMC mission statements are not yet available through MEDIPP, the teams should seek guidance from the Department of Medicine and Surgery;

The impact on outyear VAMC operating costs (e.g., will the project add or reduce operating cost and staffing needs);

The age of the VAMC facility area for which the project is scheduled (e.g., is the area scheduled for additional construction one in which recent replacement or extensive renovation work has been performed. If so, why is this additional major construction needed?);

The applicability of the space criteria and construction standards used to the particular VAMC's needs and mission (e.g., space planned vs. unassigned space, if any, at the VAMC). Also, does the team have any general concerns that the project, as planned, includes construction requirements in excess of project need or entails questionable building costs?;

If the project will result in vacating existing VAMC space, what does the VAMC plan to backfill in that area;

The availability of state or community health resources which, in keeping with eligibility, policy, and law, impact on the need for the project; and

Common sense concerns which team members might have with respect to a particular project. (Most team members will have a Regional or Medical District perspective and the project need should be evaluated in that context as well.)

WILLIAM F. SULLIVAN,
Associate Deputy Administrator for Logistics.

VETERANS' ADMINISTRATION,
April 6, 1982.

To: revalidation team members.

Subject: use of current models and methodologies and new criteria in the fiscal year 1984 revalidation process.

1. This memo reiterates and emphasizes that your revalidation work on potential fiscal year 1984 projects is to be based on the most current data, models, and methodologies available to the Agency.

2. For your reference, the following reflects recent refinements in or new criteria available to the Agency's planning and construction program. Please ensure that your revalidation reflects these current improvements to the extent possible given the stage of design of each project being revalidated.

ELECTRICAL SYSTEMS DESIGN CRITERIA

New design criteria for the sizing of electrical facilities at VA facilities has just been finalized by the Office of Construction which will reduce the incorporation of costly and inefficient unused electrical capacity. This new criteria is ready for immediate application.

NURSING HOME CARE DESIGN CRITERIA

The Nursing Home Care Cost Reduction Task Force has recently implemented cost reduction elements which will result in an estimated cost savings on a 120-bed NHCU of \$1.5 million. Wherever possible, these cost reduction features should be incorporated into potential fiscal year 1984 NHCU projects.

MORE ACCURATE WORKLOAD PROJECTION MODELS

In the last few years, Agency planners have developed more sophisticated workload projection models which should be used by the Revalidation Teams. Examples are as follows:

VA/GAO HOSPITAL BED SIZING MODEL

This model, implemented in 1980, has been made sensitive to the changing age mix and veteran migration patterns. The acute bed sizing portion of this model also is now linked to community hospital length of stay statistics and the results of the Multi-Level Care Surveys have been incorporated into the model. Further, each team is advised that on May 20, 1982, an estimate based on an 8 percent sample of

the 1980 census will be available that DM&S plans to incorporate in the VA/GAO model which might result in more accurate projections.

OUTPATIENT PROJECTION MODEL

This model was improved in late 1979 to be more sensitive to veteran population and age distribution.

NURSING HOME AND DOMICILIARY BED REQUIREMENTS MODELS

DM&S has recently updated and refined its NHC bed model and developed a new model for determining dom bed needs. Implementation of these models is dependent on the Administrator's guidance. At the request of Budget Service, DM&S will also provide Revalidation teams information on the availability of VA-supported State Homes for those states in which NHC projects are being revalidated as well as data on VA use of these State Homes.

NEW DEMOGRAPHIC DATA BASES

Revalidation Teams have available to them new demographic inputs which provide a check on the accuracy of Agency projections based on 1970 census data. For example, the new MEDIPP Baseline Submissions, submitted by the Medical Districts in January 1982, provide up-to-date hospital specific data on each facility's programs, deficiencies, and veteran demand and demography for the VAMC area. DM&S also will be generating new county specific data based on the first sample of the 1980 veteran census data which will be provided to the VA in the near future.

STAFFING STANDARDS

In 1981, the CMD established a Staffing Standards Task Force and instituted the Management Systems Service (131) in DM&S to establish staffing standards for each medical program area. Revalidation Teams should request assistance from the Assistant Chief Medical Director for Administration for revalidation of staffing standards based on the work of the task force. Also, the Teams could review a recently completed facility for a comparison between staffing projected during the planning phase and actual staffing currently on the payroll.

REVISIONS IN SPACE PLANNING CRITERIA

In the last three years (1979-1981), there have been 22 revisions approved by the Administrator in the VA's space planning criteria in 22 different functional areas. Projects being revalidated should reflect this new space planning criteria as appropriate. Areas affected include SPD, Nursing Home Care, ICU, Dietetics, Education, Cardiology Labs., etc.

VAMC MISSION STATEMENTS

While the future mission statements for VAMCs are not yet available through the MEDIPP process, Revalidation Teams should seek guidance from DM&S on whether any changes are expected in a VAMC's future mission which would impact on the project being revalidated.

ADMINISTRATOR'S GUIDANCE

An update of the 1978 Guidance is being prepared for the Administrator. Based on this updated policy options report, the Administrator will issue policy guidance which will be provided to the Revalidation Teams as soon as it is finalized. Included in the guidance will be new policies for the VA's domiciliary and nursing home care programs.

WILLIAM F. SULLIVAN,
Associate Deputy Administrator
for Logistics and Vice Chairman for FPACC.

5

COST REDUCTION ITEMS FOR IMMEDIATE IMPLEMENTATION, NURSING CARE HOMES

1. Omit provisions for vertical expansion. Provide capability only when specifically justified.
2. Adopt Modular Design Concept for Nursing Wings.
 - (a) Eliminate 4-bed patient rooms.

- (b) Use 7'-0" length patient beds.
- (c) Reduce single patient room by 10 NSF.
- 3. Use the least expensive structural system compatible with the configuration of the building and the site. Consider wall bearing with roof joints.
- 4. Toilets and bathrooms.
 - (a) Eliminate all showers and tubs in all private or shared bathrooms, connected to bedrooms.
 - (b) Eliminate urinal in congregate bath.
 - (c) Provide two full bathrooms per 60-bed unit to contain a tub, lavatory, and water closet in lieu of any bathrooms connected to a bedroom. Retain the congregate bathing facilities.
 - (d) Configure bed structure for 60 beds with: six single bedrooms; two singles with private toilet; and four singles with shared toilets for each pair of rooms; and with 27 two-bed rooms, 26 will have a shared toilet for each pair of rooms; one will have a private toilet.
- 5. Reduce dining room space by 35 percent. Meals will be served in two sittings rather than one.
- 6. Reduce recreation room space by 35 percent. The recreation and dining areas will be adjacent so that the dining room may be used for recreational activities when meals are not being served.
- 7. In lieu of male and female toilets in lobby area for visitors, use one unisex with lavatory and water closet. Use similar single unisex toilet for dining room.
- 8. Reduce social work office from 120 NSF to 100 NSF.
- 9. Reduce maximum space for rehab/rec therapists from 200 NSF to 150 NSF.
- 10. Eliminate razor blade receptacles in toilets.
- 11. Use 3'-8" x 6'-8" doors in lieu of 3'-10" x 7'-0" in patient rooms.
- 12. Do not design exterior balconies at bedrooms.
- 13. All ceilings 8'-0" in lieu of 9'-0".
- 14. When station's trash disposal uses dumpster system, eliminate trash room.
- 15. Use design discretion to eliminate or reduce skylights.
- 16. Use design discretion to reduce glass areas.
- 17. Do not provide revolving doors.
- 18. Reduce stair landings to 3'-8" deep.
- 19. Do not provide connecting corridors or tunnels unless specifically justified.
- 20. Reduce capacity of hot water generator and storage tank consistent with data obtained in past and on-going field testing conducted by Mechanical Engineering Service.
- 21. Reduce quantity of electrical convenience receptacles in patient rooms.
- 22. In home-run conduit only, permit six electrical circuits.
- 23. Reduce electrical, signal, and telephone closet depth to 12".
- 24. Select least expensive method to obtain reduced lighting levels for appropriate areas.
- 25. Where an emergency generator is necessary, locate it outside of the building structure.
- 26. Provide emergency generator only when required by code, seismic or other justifiable need which cannot be satisfied in a less expensive manner.
- 27. Use 120/208 main distribution voltage in lieu of 277/480.
- 28. Minimum conduit size will be 1/2" diameter.
- 29. Omit TV antenna outlets in all patient rooms. TV outlets shall be installed in patients' lounges and recreation rooms. In patient bedrooms, TV's may be plugged into regular electrical outlets, using portable antennae.
- 30. Use conventional standard lavatory with gooseneck spout and wrist operated faucets for wheelchair access.
- 31. Delete ceramic tile in drinking fountain alcove. Substitute heavy duty vinyl wall covering instead.
- 32. Delete requirement for non-skid ceramic/quarry tile in toilets, utility rooms and other areas not subject to standing water and/or grease. Provide non-skid surface in bath/shower areas and food preparation/dishwashing areas.
- 33. Quiet Rooms:
 - (a) Provide one Quiet Room of 180 NSF in a single-level 120-Bed NHCU.
 - (b) Provide one Quiet Room of 180 NSF in a multi-level, 120-Bed NHCU on each level.
 - (c) Provide one Quiet Room of 180 NSF in a 60-Bed NHCU.
- 34. Delete drywall protection of roof structure.
- 35. Reduce landscaping by 50 percent.

Question 9. I understand that you have placed the construction of nursing homes and domiciliaries under some kind of moratorium. This would be for 1984 and beyond. Could you please explain exactly what you are doing to this category of construction?

Answer. The Veterans Administration has not placed a moratorium on the out-year construction of nursing homes and domiciliaries. Indeed, several domiciliary projects and quite a few nursing home care projects are included on the list of projects currently being revalidated for possible fiscal year 1984 budget consideration.

The VA nursing home care and domiciliary programs, however, are being assessed by the Department of Medicine and Surgery (DM&S). In 1981, the VA's Inspector General undertook a review of the VA Domiciliary Construction Program. Based on the IG's findings, the Chief Medical Director directed a review of the Domiciliary Program mission. Re-evaluation of the space criteria standards used for VA domiciliary construction is on-going. Since DM&S was reviewing the entire DOM mission and program, no DOM projects were included in the fiscal year 1983 budget. VA is also refining its nursing home care bed model and updating the Agency's assessment of nursing home bed needs last done in 1978.

Once these assessments are completed, the Administrator will be issuing new guidance to direct the VA's construction programs in these areas.

FROM HON. BOB EDGAR TO ADMINISTRATOR NIMMO

Question 1. The Subcommittee on Hospitals and Health Care conducted an oversight hearing on the need for an outpatient clinic in Northwest Indiana on November 30, 1981. Congressman Hillis and I wrote you regarding this matter on December 9, 1981. You responded on December 17 that you were directing in immediate study to be undertaken and would respond within 60 days. Your letter to Mr. Hillis and me dated March 17 indicates your decision not to provide such a facility. Will you please furnish the Subcommittee a copy of the study you directed to be done in order that we may better understand your decision?

Answer. A feasibility study was undertaken and completed in late January 1982. A copy of the study was forwarded to Congressman Edgar, Hillis, and Representative Mottl on April 16, 1982.

APRIL 16, 1982.

Hon. RONALD M. MOTTL,
Chairman, Subcommittee on Hospitals and Health Care,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to respond to your inquiry of March 23, 1982, expressing your endorsement of an outpatient clinic in northwest Indiana, and to answer a question in reference to the same subject put forth at the April 1, 1982, hearings conducted by the House Veterans' Affairs Committee, Subcommittee on Hospitals and Health Care.

At the request of Congressmen Edgar and Hillis, the Veterans Administration conducted a feasibility study for establishing an outpatient clinic in northwest Indiana. The study includes that there is no interim alternative to providing a broad spectrum of quality outpatient services locally to veterans residing in northwest Indiana. The most appropriate alternative to meeting the health care needs of these veterans would be, if resources were available, a comprehensive satellite outpatient clinic.

The Department of Medicine and Surgery is currently assessing its program needs within each medical district through a decentralized planning process. The basis of this effort is to move the planning process to the local area where there is greater knowledge of special factors that must be considered. In this Medical District Initiated Program Planning process (MEDIPP), the demand for health care by veterans throughout the nation is being reviewed.

I have directed that decisions concerning new programs such as outpatient clinics, be deferred until MEDIPP has completed its first phase in January 1983. When the planning process is complete, the results will assist us in determining the future health care needs of the veteran population and the most cost effective manner by which to meet those needs.

As requested, I am enclosing a copy of the feasibility study for outpatient services in northwest Indiana. I am also forwarding a copy of this letter and a copy of the feasibility study to Congressmen Hillis, Edgar, and Benjamin.

Thank you for your interest.

Sincerely,

ROBERT P. NIMMO, Administrator.

FEASIBILITY OF PROVIDING ALTERNATIVE OUTPATIENT SERVICES TO VETERANS RESIDING
IN NORTHWEST INDIANA

VETERANS' ADMINISTRATION,
January 25, 1982.

Subject: Feasibility of providing alternative outpatient services to veterans residing
in northwest Indiana.

REGIONAL DIRECTOR,
Great Lakes Region
VA Central Office
Washington, D.C. 20420

1. The District Executive Council of Medical District Seventeen has carefully reviewed the study conducted by Messrs. De Nardo and Pate concerning the feasibility of providing alternative outpatient services to veterans residing in Northwest Indiana. The Council concurs unanimously with each recommendation offered, particularly the first.

2. As senior health system managers vested with the enormous responsibility of providing a wide spectrum of high quality services to an aging veteran population of over one million from throughout the greater Chicago Metropolitan Area, the need to maintain the integrity of Medical District Seventeen as a health care delivery system is considered to be paramount. To launch an adventure such as a proposed outpatient clinic in Northwest Indiana without, first of all, correcting the serious and mounting resource deficiencies threatening Medical District Seventeen invites calamity. To do so in the face of increasing fiscal austerity and uncertainty is at best injudicious utilization of scarce resources.

3. The question of access to health care services on the part of veterans residing in Northwest Indiana is a legitimate one and certainly warrants attention. However, it should be examined within the broad context of maximizing our diminishing resources, in order to continue the delivery of high quality health services to all Chicago area veterans, our *raison d'être*. Improving access to health services for veterans residing in Northwest Indiana is an issue which should be addressed in a planned and logical manner and not as an entirely independent subject.

4. The District Executive Council has directed that the question of improving access to health services for all veterans residing in areas peripheral to the District be incorporated into the Medical District Initiated Planning Process (MEDIPP). The Council also recommends that further discussion of the feasibility of an outpatient clinic in Northwest Indiana be held in abeyance pending the development and approval of the District Health Plan.

5. Your continued support and assistance is appreciated in this matter.

JOHN R. FEARS,
Medical District Director.

VETERANS' ADMINISTRATION,
January 25, 1982.

To: Medical district director.

Subject: The feasibility of providing alternative outpatient services to veterans residing in northwest Indiana.

1. As directed, the feasibility of providing outpatient services locally to veterans residing in Northwest Indiana as an alternative to the present provision of such services at the Hines VA Hospital, The Lakeside or West Side VA Medical Centers, has been carefully examined. Three modalities for providing outpatient services were selected for analysis and appropriate criteria were developed to assess the effect each would have upon not only improving the health status of veterans residing in Northwest Indiana, but also upon the patient care mission of the three tertiary care health care facilities in Medical District Seventeen.[1] The three modalities selected are each currently being utilized [2] within the Veterans Administration's Health Delivery System and represent viable alternatives to providing outpatient services to veterans for whom remote geographical access to a VA medical center impedes utilization. Sufficiently meaningful data was obtained from several medical centers utilizing these modalities to facilitate the projection of resource requirements to meet the direct and indirect, or referral workload anticipated from each.

2. In addition, the study addresses separately three issues which are central to the determination of the feasibility of providing outpatient services to veterans residing

Footnotes at end.

in Northwest Indiana.[3] The format employed to facilitate the analysis of alternative outpatient services focuses upon:

I. Demographic and Epidemiological Characteristics of the Veterans Population in Northwest Indiana.

II. Resource Requirements Associated With the Provision of Outpatient Health Services to Veterans Residing in Northwest Indiana.

III. Analysis of the Impact Which the Provision of Outpatient Services to Veterans Residing in Northwest Indiana Would Have Upon Medical District Seventeen Workload and Resources.

IV. Typology of Outpatient Services Provided and Associated Resource Requirements.

V. Conclusions and Recommendations.

3. A cautionary note is sounded with regard to much of the data used and, ipso facto, with the estimates derived. Specifically, with regard to estimated resource requirements, rather conservative assumptions were made of the inpatient workload which would inexorably result from the activation of either a primary care or a comprehensive satellite outpatient clinic.[4] In addition, the estimates used to project the staff necessary to provide outpatient services in a clinic setting were considerably less, by as much as twenty-six percent (26 percent)[5] than the estimates provided at the House Veterans Affairs Subcommittee on Hospitals and Health Care Oversight Hearing held on November 30, 1981 in Gary, Indiana (See Attachment B). Consequently, the estimated resource requirements should be viewed as being, indeed, very conservative; perhaps even to the extreme. A further point to be made is that this study did not address, nor did it attempt to, the probable effect which the activation of an outpatient clinic in the Gary, Indiana area would eventually have upon the community nursing home care program within Medical District Seventeen. However, it seems axiomatic that any increase in the demand for nursing home care, which the activation of an outpatient clinic would surely and inevitably have, would necessitate a corresponding increase in the resources required to support such a program. Once again, the overly conservative nature of the estimated resource requirements is manifested. True costs would probably be in excess of the projected costs.

4. The determinative issues surrounding the proposal to provide alternative outpatient services to veterans are essentially three in number. The first addresses the size and age distribution of the veteran population to be served. The second issue examines the rather complicated manner through which the resources necessary to provide the proposed services are identified. The third and final issue dealt with [6] the impact which the activation of an outpatient clinic would have upon Medical District Seventeen.[7] For the sake of elucidation, these issues are analyzed independently.

5. I—Demographic and Epidemiological Characteristics of the Veteran Population in Northwest Indiana.

Over 168,000 veterans resided in Northwest Indiana in fiscal year 1981 (Table 1). During the prior fiscal year (1980), 1327 episodes of inpatient care were provided to these veterans who, in addition, accounted for 10,352 of the outpatient visits in Medical District Seventeen (See Attachment C). Veterans from Lake County in Indiana, who comprise nearly half of the veteran population in Northwest Indiana (Table 1), utilized both the inpatient and the outpatient services of medical district seventeen in disproportionate amounts in fiscal year 1980. As Attachment C indicates, veterans residing in Lake County accounted for 78.8 percent of the inpatient episodes of care and 83 percent of the outpatient visits provided veterans from Northwest Indiana.[8] In light of this fact, the visit rate projections for veterans residing in Lake County may be less than experience would otherwise indicate. The point to be made here is that the anticipated visit rate, as shown on Table 1 and used as an indicator of the demand for services, may be, in the case of Lake County in particular, far too conservative.[9] Although similar data is not completely available [10] for fiscal year 1981 there is no evidence to suggest that any variation in the above cited utilization patterns is warranted.

While the total veteran population in Northwest Indiana will decline by approximately 9 percent between 1980 and 1990, the number of aged veterans [11] will more than double (Table 2) during that period. In fact, veterans 55 years of age or older will comprise over 42 percent of the total veteran population by 1985 and this distribution will remain relatively constant through 1990. Of equal interest is the bimodal distribution found in the analysis of the veteran population, by age, in Northwest Indiana. Not only are those veterans 55 years of age or older now a dominant element in the total veteran population, so too are those veterans aged 25 to 44 years of age. The dominance of both groups continues into the future. Consequently, from

a health planning standpoint, one would want to structure the services provided to the disabilities inherent to each group. The former age grouping of veterans, those 55 years of age or older, would be expected to evidence diseases which befall older Americans in general; heart disease, neoplasms, circulatory and digestive disorders, and impaired pulmonary function to name a few. Among the latter group of veterans, those in the 25-44 age range, one would expect to find psychiatric and what are termed "life style" diseases most frequently.

An analysis of the primary discharge diagnoses of Northwestern Indiana veterans discharged in fiscal year 1981 from Medical District Seventeen Health Care Facilities clearly supports the above hypothesis in terms of their major health care needs (Table 3). Approximately 70 percent of the 1400 veterans from Northwestern Indiana treated as inpatients suffered from diseases typically found in an aging population. The second most frequent diagnostic category found was for psychiatric illnesses. While not adjusted for age, the 25-44 year old age range would likely be the group requiring psychiatric treatment. This data is in keeping with data collected system wide by the Veterans Administration.[12] However, considering the socio-economic dynamics of Northwestern Indiana a higher percentage of discharges for psychiatric treatment might have been postulated.[13] The fact that only primary discharge diagnoses were analyzed was certainly an influence in categorically determining the major health care needs of the veterans residing in Northwest Indiana.

Although one can estimate, hopefully to a reasonable degree, the veteran population in Northwest Indiana, the rate at which they would utilize locally available outpatient health services and their major health needs, a more important question is left unanswered. Specifically, how many service connected veterans would utilize the services of a proposed outpatient clinic in Northwest Indiana. If, in fact, the major health care needs of veterans residing in this area are, as has been hypothesized, diseases associated with aging, what are termed "life-style" diseases and, finally, psychiatric illnesses, the majority of which relates to substance abuse, then they would in all likelihood be non-service connected in nature. The significance of this point will be made later.

6. II—Resource Requirements Associated With the Provision of Outpatient Health Services to Veterans Residing in Northwest Indiana.

The three modalities of care selected for analysis each represent escalating alternatives to the provision of outpatient services locally to veterans residing in Northwest Indiana. They vary both in terms of services offered and the number of patients which can be treated, expressed as outpatient visits. More importantly, they vary tremendously in the total resource requirements necessary to completely support each modality. In determining the total costs associated with each modality, particularly the second two, several considerations had to be weighed. Inasmuch as only certain clinical services will be provided at the clinic itself, a number of patients will, of necessity, be referred to the parent health care facility for specialty care, either on an inpatient or an outpatient basis. Viewing the activation of a clinic in its totality then required that estimates be derived of the additional inpatient and outpatient workload which the parent facility would have to support. These estimates were made after examining the referral patterns of the VA Outpatient Clinic in Toledo, Ohio and after analyzing the discharges, by county of residence, in fiscal year 1981 from the VA Medical Center in Ann Arbor, Michigan.[14] Once again, the anticipated inpatient workload resulting from the activation of an outpatient clinic was estimated at a rate considerably less than actual experience would dictate.

Another consideration made was to reduce the estimated total costs of an outpatient clinic in Northwest Indiana by the amount of resources consumed providing fee basis medical care to veterans from the same area. While not all veterans in Northwest Indiana receiving fee basis care would be treated at a clinic the vast majority presumably would. In any event, the actual fiscal year 1981 fee basis medical costs for Northwest Indiana were used to offset the total costs associated with the activation of a clinic with the full knowledge that such an offset in funds is overly optimistic.

A final consideration, and perhaps the most significant by far, was the manner in which cost estimates were derived. So as to allow for comparison of the costs of services over time wherever possible, actual fiscal year 1981 costs were used. Costs associated with the suggested interim medi-van concept were patterned after the same service offered by the VA Medical Center in Denver, Colorado. The costs incurred with the activation and operation of an outpatient clinic were determined after reviewing data relative to the VA Outpatient Clinic in Toledo, Ohio. Somewhat more problematic was the assessment of the costs which the parent facility could be expected to incur as a result of specialized inpatient and outpatient services. It seemed

reasonable to conclude that the costs incurred by the parent facility in support of an outpatient clinic would be largely incremental in nature. Consequently, it became necessary to identify the variable, or incremental, costs associated with providing both inpatient and outpatient support to an outpatient clinic. The use of the (prospective reimbursement intradistrict methodology) methodology [15] was seized upon for it dealt, first of all, with only recurring costs and, secondly, it utilized weighted work units to determine relative costs for both outpatient visits and for numerous (discharge) diagnostic groupings. A more simplistic and far easier method of determining the costs in question would have been to apply the per diem costs of any one of the three tertiary care hospitals in Medical District Seventeen to determining the costs of inpatient services provided and using an arbitrary cost for each referral outpatient visit. However, in the first case fixed costs are included and in the second the selection of an arbitrary figure would obviously misrepresent the costs of the service; to say nothing of violating one's sense of propriety. Consequently, the methodology surrounding the use of prime as an allocation mechanism, with their basis in logic and reliance upon empirically derived relative costs, was clearly shown to be most appropriate.

In their letter to the Administrator of Veterans Affairs two members of the House Committee on Veterans Affairs stated that "As an interim solution for this situation, we suggest that staff be sent from one or a combination of all of the Chicago VA facilities to a location in Northwest Indiana for the number of days required each week to provide outpatient services to these veterans". [16] The interim solution selected in response to this proposed alternative was the use of a medi-van; a modality currently utilized by the Denver, Colorado VA Medical Center to provide outpatient services to veterans residing in remote areas. The van is essentially a physicians office on wheels. [17] The van and its staff of one physician and one licensed practical nurse travel to different locations four days a week treating scheduled patients who have chronic illnesses and who are selected for the program after having initially been treated at the medical center. Donated space, such as service organization meeting halls, serve as the rendezvous point for the patients and as a waiting room for those waiting to be seen by the physician. Those medications not provided the patients at the time they are seen are subsequently mailed from the Denver VA Medical Center. The costs of providing a similar service to veterans residing in Northwest Indiana are set forth in Table 4.

The singular attraction of this modality is the relative timeliness with which it can be effected. Beyond that it pales. Not only will but a small percentage of patients benefit, they will do so by simply having greater access for essentially routine follow-up care. Patients eligible for such a program would, first, have to be in a clinic at the parent facility and determined to be clinically appropriate candidates. By definition they would be required then to be seen, evaluated and even treated at the parent facility. Only patients with chronic diseases and already on an established treatment regimen would be seen by the medi-van and those seeking care for acute conditions, or walk-ins, would be referred to VA facilities in Medical District Seventeen. If the projected visit rate of over 53,000 outpatient visits (Table 1) is indicative of the demand for such services among veterans in Northwest Indiana, then this particular alternative is minimally responsive. The 3,100 outpatient visits a medi-van could provide is a mere 6 percent of the estimated demand and only 15 percent of the 20,000 staff and fee outpatient visits experienced in fiscal year 1980 from veterans residing in Northwest Indiana. [18] Services would be strictly limited and do little, if anything, to address the major health needs of veterans residing in the area (Table 3).

The second alternative examined was the activation of a primary care outpatient clinic (Table 5). In addition to providing the same services which the medi-van would, on a much broader scale of course, a primary care clinic would emphasize basic or general health services. It would serve as the point of initial contact for the patient with the VA's health delivery system and make referrals, as appropriate, to Medical District Seventeen for secondary and tertiary care. By virtue of its designated mission a primary care outpatient clinic would not be structured to meet the health needs of the entire veterans population in Northwest Indiana on an outpatient basis. An analysis of the workload at the VA Outpatient Clinic in Toledo, Ohio indicated that approximately 66 percent of the visits made to the clinic in fiscal year 1981 were for primary kinds of care. That factor was then applied to the anticipated visit rate data reflected on Table 1 to derive a projected level of utilization for an outpatient clinic providing essentially primary kinds of care. Table 6 presents the recurring and non-recurring, or one time activation, costs of providing primary care outpatient services with an estimated level of demand for 35,441 visits in fiscal year 1981. [19] Personnel requirements reflects the more conservative 1.0 FTEE for

every 500 anticipated outpatient visits. Supply and Beneficiary Travel costs were based upon similar cost requirements per visit at the VA Outpatient Clinic in Toledo, Ohio. Second only to Personnel costs the lease costs were the most significant recurring cost. Although Congressmen Edgar and Hillis suggested that "many witnesses expressed the opinion that suitable space could be found at no charge to the Veterans Administration"[20] the belief that there is sufficient largess in the community to donate approximately 35,000 square feet of clinically appropriate space for a clinic was not incorporated in the cost analysis.[21] Consequently, estimated lease costs were included. This same logic was utilized to estimate strictly the costs of outpatient services through fiscal year 1990.

If one were to look solely at the costs of staffing a primary care outpatient clinic and responding to an estimated 35,000 visits the necessary recurring funds would total approximately \$2,541,000.[22] However, such would be a myopic view. The establishment of an outpatient clinic in a heretofore under served areas[23] will not only provide a measure of service not previously available. It will identify patients requiring specialized care on either an inpatient or an outpatient basis. The structure of an outpatient clinic presupposes that the more sophisticated services will be provided by the parent facility.[24] Therefore, it was necessary to not only estimate, in a logically derived manner, the degree of support that a parent facility must provide, but also, the costs of such support. To do otherwise, as has been mentioned, would be to intentionally overlook the resource requirements necessary to sustain the mission of an outpatient clinic.

The experience of the VA Outpatient Clinic in Toledo, Ohio in utilizing the parent facility, the Ann Arbor, Michigan VA Medical Center, for support was used as an empirical measure of the support that would be provided to a similar outpatient facility. Fiscal year 1981 workload data obtained from the Toledo Outpatient Clinic indicated that approximately 12 percent of the visits to the clinic itself were later referred to one of several specialty clinics at the Ann Arbor VA Medical Center.[25] Inpatient support was determined in a like manner. Of the 8,084 discharges from the Ann Arbor VA Medical Center in fiscal year 1981, less hemodialysis, 1,634 of those, or 20.21 percent of the veterans resided in counties served by the Toledo Outpatient Clinic. This figure was adjusted to exclude those veterans residing in a few Michigan counties served by the clinic and the adjusted percentage of 12.7 percent was obtained. The adjusted 12 percent figure was consistent with previously obtained data concerning the utilization of Medical District Seventeen Health Care Facilities by veterans residing in Northwest Indiana (Attachment C).

A far more challenging exercise was estimating the costs associated with providing both inpatient and outpatient support services to the outpatient clinic by the parent facility. As has already been mentioned, the prospective reimbursement intradistrict methodology (PRIME) was used to identify the variable costs that would be incurred by the parent facility in support of an outpatient clinic in Northwest Indiana. Rather than launch into a discussion of the intricacies of the prospective reimbursement intradistrict methodology which would, of necessity, be quite lengthy, I will summarize the manner in which incremental costs for both inpatient and outpatient workloads was arrived at.[26] The total number of weighted work units generated from the treatment of outpatients and inpatients alike in fiscal year 1980 were divided into the fiscal year 1981 recurring base for Medical District Seventeen to arrive at a cost per weighted work unit.[27] The resulting figure was used to reflect recurring or, in this case, incremental cost per weighted work unit. The number of inpatient weighted work units were then divided by the number of discharges to derive an average number of weighted work units per discharge. Variable or incremental costs per discharge were then determined by multiplying the cost per weighted work unit by the average number of weighted work units per discharge. Arithmetically, the variable costs per inpatient episode of care were estimated to be \$1,747.50. The variable costs per outpatient visit were estimated to be \$51.34.[28] These figures were then multiplied by the number of projected inpatient and outpatient referrals, respectively, made by an outpatient clinic to the supporting parent facility to arrive at the total recurring composite costs of providing primary care services to veterans residing in Northwest Indiana.

In addition to segmenting the recurring costs associated with the provision of primary care outpatient services, Table 6 identifies the non-recurring, or one time, activation costs which would be incurred.[29] Given the high degree of probability that a newly activated primary care outpatient clinic in Northwest Indiana could meet, and possibly even exceed, it's assigned workload of 36,000 visits[30] in the first full year of operation, the total costs, including activation costs, would minimally amount to \$7,116,900.

The logic employed to calculate the costs associated with the provision of comprehensive satellite outpatient clinic services is the same as that just discussed in estimating the total costs of a primary care outpatient clinic. The obvious differences in estimated workloads for the two clinics comes as a result of their different missions. The primary care clinic would treat certain acute illnesses and provide follow-up care from patients suffering from a limited number of chronic diseases. The comprehensive satellite outpatient clinic, on the other hand, would provide a broad spectrum of diagnostic and therapeutic health care services designed to not only meet the primary care needs of an aging veteran population, but more importantly, to obviate their need for hospitalization.[31] Consequently, the latter modality would be expected to treat more patients and, hence, the greater assigned workload. Parenthetically, the visit rate estimated in Table 1 assumes the availability of a comprehensive, as opposed to a primary care, outpatient clinic. Along with an increased workload one could reasonably anticipate an increase in the number of patients referred to the supporting parent facility for either specialized outpatient services or for inpatient care.[32][33]

Table 8 reflects the recurring costs, by component, that would be incurred as well as the one time activation costs of a comprehensive satellite outpatient clinic. Such a clinic could, in light of available evidence, reasonably be expected to provide for 54,000 outpatient visits in the first full year of operation. In that case, the total first year costs would, minimally be \$10,526,544.

While the estimated cost per visit to a hypothetical comprehensive satellite outpatient clinic is marginally less than the estimated cost per visit to a primary care clinic, the costs associated with the provision of sophisticated and necessary clinical support by the parent health care facility vary dramatically. The variance in support costs is due to the underlying variance in the degree of support required by each type of outpatient clinic. Although the preceding discussion has focused upon the escalating costs, both direct and indirect, of providing three alternative modalities of care it should not be construed to have also identified the one most effective in responding to the health care needs of veterans residing in Northwest Indiana. Such question is addressed in the conclusion of this study.

7. III—Analysis of the Impact Which the Provision of Outpatient Services to Veterans Residing in Northwest Indiana Would Have Upon Medical District Seventeen Workload and Resources.

The three modalities examined as possible alternatives to the provision of outpatient services to veterans residing in Northwest Indiana were each analyzed to determine their impact upon Medical District Seventeen.[34] Tables 9 and 10 reflect the impact which a primary care and a comprehensive satellite outpatient clinic, respectively, would have. Suffice it to say that a medi-van, by virtue of the limited number of carefully selected patients to which it could provide only a few services would have little, if any, discernable effect upon either the Medical District or upon improving the health status of the large, aging veteran population in Northwest Indiana. Were such a modality to be selected, for whatever reason, recurring and non-recurring funds are not available from within the Medical District to support the program.[35]

Given the fact that, if selected, the medi-van would have to be funded from a source other than Medical District Seventeen and its terribly limited impact, the effect of this particular alternative is dealt with narratively.

Far and away, more significant is the effect which either of the remaining two modalities would have upon the resources and workloads in Medical District Seventeen. Tables 9 and 10 illustrate this point quite well,[36] although not completely. The resource base, expressed as medical care funds, of the three tertiary care medical centers deteriorated by more than 8 percent between fiscal year 1981 and fiscal 1982. Such a deterioration does not even reflect the additional effect an insidious inflation rate has upon an already overburdened health care system. In the case of both clinics, a considerable increase in the workload of the Medical District would result. Obviously, the comprehensive satellite clinic would be the more significant of the two.

One of the critical assumptions made in analyzing the workload impact of these two outpatient clinic alternatives was that should one be selected, all composite costs would be fully funded from other than Medical District Seventeen resources. It is inconceivable that in fiscal year 1982, for example, facing an erosion of over 8 percent in the prior years funding, the Medical District would be expected to absorb an additional \$6 to \$9 million dollars in costs.

The question of what impact an outpatient clinic providing either primary or comprehensive services to veterans residing in Northwest Indiana would have upon Medical District Seventeen belies the severity of the current and future resource de-

iciency the District faces. One by no means has cause to be sanguine as to the ability of the four VA medical facilities in Medical District Seventeen to continue to provide a broad spectrum of high quality health care services to veterans from throughout the greater Chicago metropolitan area. There exists, at present, a demonstrated need for over \$14,500,000 (Attachment D) to simply maintain the present level of health services being offered. This is an addition to a shortfall in recurring funds in fiscal year 1982 in excess of \$2,800,000[37] which will have to be absorbed by the Medical District. The unfortunate, albeit preventable, consequences of these mounting deficiencies are a concomitant reduction in the numbers and quality of patient care services which can be provided and the increased jeopardization of Medical District Seventeen as a viable health care delivery system.

Projected future needs for capital improvements to remain responsive to the needs of an aging veteran population must also be considered in arriving at a determination of the most appropriate manner in which diminishing resources can be utilized. Through fiscal year 1990 the Medical District has identified over \$142 million in capital improvements projects necessary to continue to fulfill its trifold mission.

In light of an increasing emphasis upon fiscal austerity in the Federal sector as being sound public policy and as a result, almost draconian efforts to attain the most judicious utilization of resources, the present question of providing additional services begs redefinition. The issue to be joined, properly articulated, is not, as has been suggested, the feasibility, or even desirability, of providing alternative outpatient services to veterans residing in Northwest Indiana. Rather, the issue is one of whether the integrity of an already existing health delivery system will be consciously allowed to wane. Certainly, if funds are specifically appropriated for said purpose, an outpatient clinic can be activated to provide health services to veterans residing in Northwest Indiana. However, to infuse resources into Medical District Seventeen for such purpose without substantially correcting existing resource deficiencies would require the application of criteria contrary to those inherent in a rational and logical approach to health planning.

8. IV—Typology of Outpatient Services Provided and Associated Resource Requirements.

Cost based criteria were developed to analyze the effectiveness of each modality under examination and to provide quantifiable data to assist those vested with the responsibility of determining, if necessary, which modality is most appropriate to the health needs of the veterans residing in Northwest Indiana.

A second criteria developed and subjectively applied was the impact each alternative modality could reasonably be expected to have upon improving the health status of the veteran population to be served.

The feasibility of utilizing a medi-van to provide health services has already been addressed and found lacking. The low cost per visit veils the fact that only very limited services will be provided, by appointment, to a carefully selected group of chronically ill patients. The medi-van will only serve to negate a visit to a VA health care facility for a very few number of the veterans in need of having their treatment regimen periodically monitored. While such an alternative may be attractive to those who are more interested in form than substance, it represents an irresponsible utilization of scarce resources in a Medical District facing an uncertain future, at best, due to mounting budgetary deficiencies.

Perhaps the most meaningful indicator of effectiveness, at least in a purely economic vein, is the cost of a service per unit of measure. In the case of either a primary care or comprehensive satellite clinic the most appropriate unit of measure is an outpatient visit. Therefore, in planning for a particular health service, in this case an outpatient clinic, one would be particularly interested in the costs (per outpatient visit) in determining which modality represents the most (cost) effective alternative. Table 11 examines the three modalities initially presented as alternatives to the provision of outpatient health services to veterans residing in Northwest Indiana. The question of a medi-van has already been discussed and will not be reiterated here. It should be obvious by now that such an alternative is nothing more than window dressing and does not merit further consideration.

If one examines the remaining two modalities with a view toward purchasing as it were, that alternative which provides the greatest range of services at the lowest unit cost one is compelled to select the comprehensive satellite outpatient clinic. While there is no significant difference in the unit costs of these alternatives, in either the activation year or in subsequent years, the range of available services vary considerably. Consequently, the impact each would likely have upon the health status of the veterans served could also be expected to vary. In the final analysis then, with no significant difference between the two in terms of the costs per visit,

attention is focused upon the impact each would have upon improving the health status of the population to be served. Clearly, a comprehensive satellite outpatient clinic would have a significant, albeit subjectively determined, effect upon improving the health status of the veteran population to be served.

The recommended prioritization of the three alternatives examined reflects an assessment of the cost-effectiveness and potential each would have for improving the health status of the veteran population served. This not to say that a comprehensive satellite outpatient clinic should be established to serve the health care needs of veterans residing in Northwest Indiana. Rather, it is to say that should the decision be made to provide outpatient health care services locally to the aforementioned veterans the most appropriate modality from the standpoint of costs and effect upon improvement in health status would be a comprehensive satellite outpatient clinic.

9. V—Conclusions and Recommendations.

Congressmen Robert Edgar and Elwood Hillis, in their letter of December 9, 1981 to the Administrator of Veterans Affairs, [38] spoke of the "difficulties of utilizing the outpatient facilities at the VA Medical Centers in Hines, West Side, and Lakeside in the Chicago area" which veterans residing in Northwest Indiana experienced.

Their concern over whether veterans with service connected disabilities have sufficient access to health care can be allayed by pointing out the extent to which this particular group of veterans utilizes, or is entitled to use, the fee basis medical program. The matter of access to health care services for service connected veterans then, is moot. The remaining issue, vis-a-vis access, is one which seems to advocate locally available outpatient services for a veteran population locally available outpatient services for a veteran population beset, in the main, with non-service connected disabilities of age. With Medical District Seventeen suffering from burgeoning resource deficiencies the commitment of increasingly scarce resources to embark upon a venture which is designed to respond to essentially non-service connected health care needs is not a judicious utilization of those resources. A more appropriate employment of those very same resources would be toward the existing deficiencies which endanger the ability of Medical District Seventeen to continue to provide a broad spectrum of high quality health care services to all veterans from throughout the greater Chicago metropolitan area.

The congressmen also mentioned an interim solution as being a trilateral effort by the tertiary care VA health care facilities to provide outpatient services locally in some unidentified manner. This suggestion is both administratively and logistically impractical and would surely lead to sub-optimal patient care. More importantly, however, is the irrepressible fact that there simply is no interim solution for the provision of outpatient health care services locally to veterans residing in Northwest Indiana. The reality of attempting to provide even minimally adequate health care services to 168,000 veterans, the majority of which are of advanced age, prohibits facile solutions.

In light of the rather voluminous data collected surrounding the entire issue of locally provided outpatient health care services for veterans residing in Northwest Indiana, the following recommendations are made:

Recommendation 1—That the serious resource deficiencies which plague Medical District Seventeen be corrected prior to the consummation of a decision to establish an outpatient clinic within the District.

It must be recognized that, notwithstanding the above recommendation, a decision may emanate from a higher council to proceed with plans to establish an outpatient clinic designed to locally serve the needs of veterans residing in Northwest Indiana. In such case the following recommendations are made:

Recommendation 2—That a comprehensive satellite outpatient clinic be selected as the most appropriate modality.

Recommendation 3—That either the Hines VA Hospital, the Lakeside VA Medical Center or the West Side VA Medical Center be designated as the parent facility for said clinic.

Recommendation 4—Prior to the activation of said clinic a complete study of all costs associated with the provision of comprehensive outpatient services be conducted.

Recommendation 5—That the recurring and non-recurring resources made available to support said clinic be not less than those identified in the pre-activation cost study.

The opportunity to provide any further assistance in this matter is eagerly awaited.

JOHN DE NARDO,
*Assistant Director Trainee,
VA Hospital, Hines, Ill.*

A. S. PATE,
*Assistant Director Trainee,
West Side VA Medical Center, Chicago, Ill.*

FOOTNOTES

1. Veterans Administration Hospital, Hines, Illinois; Veterans Administration Medical Center (Lakeside), Chicago, Illinois; Veterans Administration Medical Center (West Side), Chicago, Illinois.

2. The modalities selected for analysis were the medi-van concept as utilized by the Denver, Colorado VA Medical Center and the comprehensive satellite outpatient clinic concept which is represented by the VA Outpatient Clinic in Toledo, Ohio. Parenthetically, the VA Medical Center in Ann Arbor, Michigan is the parent health care facility for the Outpatient Clinic in Toledo, Ohio. The primary care outpatient clinic modality is evident in all VA medical centers although in varying degrees of size and often times referred to as the General Medical Clinic.

3. For the purposes of this study, the area commonly referred to as Northwest Indiana includes the following counties in Indiana: Lake, Porter, LaPorte, Newton, Jasper, Starke, Marshall, Pulaski and St. Joseph. Kankakee County in Illinois has also been included in this definition. Attachment A illustrates the proposed primary service area (PSA) for any of the three modalities presented as alternatives to the provision of outpatient health services to veterans in Northwest Indiana.

4. Although developed more completely in the discussion of both primary care and comprehensive satellite outpatient services a factor of six percent (6 percent) inpatients treated resulting from the anticipated outpatient visits was utilized. Actual discharge data from the VA Outpatient Clinic in Toledo, Ohio and from the three tertiary care hospitals in Medical District Seventeen suggests that a twelve percent (12 percent) factor for derived inpatients treated would be more appropriate. The more conservative six percent (6 percent) factor was utilized due to a lack of definitive research data reflecting the inpatient workload resulting from the activation of an outpatient clinic in the VA's health delivery system.

5. Inserted into the testimony of Mr. A. Zamberlan, Regional Director of the Great Lakes Region, on page 61, Line 1467 was the following statement regarding the staffing for an outpatient clinic in the Gary, Indiana area: "In a clinic serving an area such as the metropolitan Gary area there would be: 119 general medical and surgical personnel to include physicians and nurses; 7 psychiatry to include physicians and nurses and 21 support personnel, which includes, 1 chief medical officer, 6 medical administrative staff, 3 laboratory, 3 radiology, 3 rehabilitation medicine staff, 3 pharmacy staff, 1 prosthetic and 1 dietetics.

Although a total of one hundred and forty seven employees would certainly be sufficient to provide services in an outpatient clinic, the ratio of staff to outpatient visits proposed by Mr. Zamberlan in his testimony (page 61, lines 1462-1465) of one employee per 500 outpatient visits was employed. In terms of associated resources, the more conservative ratio proposed by Mr. Zamberlan would require \$890,097.00 less in recurring personal services funds, thereby reducing the costs per visit by at least \$16.57. Perhaps the significance of using a conservative staffing estimate is more evident in the percentage of variance between the two in associated resources. The more conservative proposal of Mr. Zamberlan would result in a 26.54 percent reduction in personal services costs and, minimally, a 19.12 percent reduction in the cost per visit for a comprehensive satellite outpatient clinic.

6. A number of peripheral issues are either not addressed in their entirety or intentionally not addressed at all. Rather, they are identified for future consideration. For example, the fact that there should be but one parent facility for a proposed outpatient clinic in lieu of a trilateral approach to management of the clinic is, for the present, simply acknowledged. It is both beyond the intent of this study and also quite inappropriate to attempt to identify which VA medical center in Medical District Seventeen be vested with that responsibility.

7. Unless otherwise specified, any reference to Medical District Seventeen is directed collectively to the Hines VA Hospital and the Lakeside and West Side VA Medical Centers.

8. It is significant to note, that the demonstrated demand upon Medical District Seventeen health care facilities in fiscal year 1980 was for 10,352 outpatient visits and 1,327 episodes of inpatient care. From another point of view, one might well plan for the provision of inpatient care by using the reciprocal of the the ratio of

inpatient to outpatient workload, or 1,282, to derive the number of discharges that could reasonably be anticipated given a projected number of outpatient visits. However, in estimating the associated inpatient workload for the two outpatient clinic models used a much more conservative estimate was applied. What is of particular importance here is that actual experience would support, perhaps even require, a higher estimate.

9. To better illustrate this point reference is made to the data previously noted in Attachment C and projected visit rates in Table 1. If one were to rely upon Table 1 veterans residing in Lake County would account, or would have accounted for 34,494 of the estimated 53,698 outpatient visits that were projected in fiscal year 1981. Or, to put it another way, 64.24 percent of the projected outpatient workload. As an aside, the visit rate calculations are based upon estimated visits per 1,000 veterans population and are a function of the distance of the county in question from a clinic, were one located in Lake County. The visit rate ratio applied to Lake County was .435. What is being suggested, is that veterans from Lake County, the most populous in Northwest Indiana, would utilize an outpatient clinic to a greater extent than anticipated. Despite the distance from the three VA health care facilities which provide services veterans from Lake County accounted for 83 percent of the outpatient care provided veterans from Northwest Indiana. With a clinic located within the county having the largest veteran population in Northwest Indiana those veterans residing in Lake County can reasonably be expected to utilize to a greater extent the health care services available in terms of both gross numbers and as a percent of the total.

10. While data reflecting the utilization of inpatient services in fiscal year 1991 by veterans residing in Northwest Indiana was available for analysis, the number and distribution of outpatient visits among those same veterans could not be extracted.

11. Sixty-five years of age or older.

12. U.S., Veterans Administration, "1980 Annual Report." (Washington, D.C.: Government Printing Office, 1981), pp. 41-43.

13. August B. Hollingshead, Ph. D. and Fredrick C. Redllich, M.D., "Social Class and Mental Illness" (New York, New York: John Wiley and Sons, Inc. 1958).

14. The Ann Arbor VA Medical Center is the parent facility for the VA Outpatient Clinic in Toledo, Ohio.

15. In addition, this method of resource allocation is being used in Medical District Fourteen and is under study at the Central Office level as a mechanism by which to allocate future resources system wide. It will also be used in fiscal year 1983 in the Great Lakes Region to monitor the actual allocation of resources.

16. Edgar, Robert W. and Hillis, Elwood, Members, U.S. House of Representatives, Committee on Veterans Affairs, Washington, D.C. Letter to Robert Nimmo, Administrator of Veterans Affairs, Veterans Administration, Washington, D.C., Dec. 9, 1981.

17. In the event that any of the three modalities analyzed is ultimately selected, the suggestion that there be trilateral management of the venture should be immediately resolved in favor of a single parent facility. In and of themselves, medical centers are complex institutions. Any effort by three different, highly affiliated, tertiary care medical centers to share in the clinical and logistic support of a newly activated outpatient program poses serious challenges to the efficient delivery of services.

18. U.S. Congress, House Committee on Veterans Affairs. "Need for a VA Outpatient Care Facility in Northwest Indiana, Hearings," before the subcommittee on Hospitals and Health Care in Gary, Indiana on Nov. 30, 1981, p. 47.

19. The estimated outpatient visit rate for primary care was derived by taking the factor of .66 and applying it to the estimated visit rate for the entire veteran population as shown in Table 1 ($53,698 \times .66 = 35,441$ estimated visits for primary care). This figure is somewhat conservative in light of the experience of the VA Outpatient Clinic in Toledo, Ohio. In fiscal year 1981 the clinic experienced 32,009 outpatient visits, of which 17,996 were to the General Medical Clinic and another 5,344 were "walk-ins". Together these two clinics would be the core of a primary care program and constituted 72.9 percent of the workload of the clinic. A more conservative .66, or 66 percent of the total demand for outpatient services (See Table 1—53,698 visits in fiscal year 1981) was used based upon the same logic outlined earlier; lack of definitive research.

20. Edgar, Robert W. and Hillis, Elwood, Members, U.S. House of Representatives, Committee on Veterans Affairs, Washington, D.C. Letter to Robert Nimmo, Administrator of Veterans Affairs, Veterans Administration, Washington, D.C., Dec. 9, 1981.

21. In the case of the comprehensive satellite outpatient clinic approximately 50,000 square feet of clinically appropriate space would be required.

22. Unless otherwise specified all costs are reflected in terms of the estimated cost of the goods or service in fiscal year 1981.

23. The comment that Northwestern Indiana is under served does not mean, nor should it be interpreted to mean, that veterans residing in this area are not provided adequate health services. They are served by any one of three tertiary care facilities in Medical District Seventeen and over 14,000 visits were made collectively to these medical centers in fiscal year 1980. In the context of this study underserved refers solely to the question of access. One can even qualify access to be convenient access.

24. Not unlike the HMO (Health Maintenance Organization) model with a hospital or medical center providing the more expensive services on a referral basis.

25. In fiscal year 1981 the VA Outpatient Clinic in Toledo, Ohio provided 32,009 clinic visits to veterans in their service area. A total of 4,009 referrals were made to specialty clinics at the Ann Arbor, Michigan VA Medical Center. The derived percentage of referrals was 12.52 percent.

26. As already noted per diem rates were not used to calculate the costs of inpatient referrals as they include fixed costs that are not appropriate in determining the additional, or variable costs for specialized support of a satellite out-patient clinic.

27. For a complete discussion of the logic employed in the development and application of the prospective reimbursement intradistrict methodology refer to: U.S. Veterans Administration, Department of Medicine and Surgery, "Prospective Reimbursement Intradistrict Methodology (PRIME)," developed by the Health Services Research and Development Program, VA Medical Center, Ann Arbor, Michigan, Mar. 15, 1980.

28. In comparing the estimated variable costs per inpatient episode with the per diem costs significant variances are found. Using a 20 day length of stay at the Lakeside VA Medical Center the costs of an inpatient episode, using the September 1980 per diem cost, would be \$4,030.00. However, using the estimated variable costs that same episode of inpatient care would cost \$1,747.50 or, put another way, the difference in the per diem costs and the variable costs for the same episode of care was \$2,282.50. Variable per diem costs were estimated to be \$87.37 while the reported per diem costs at the Lakeside VA Medical Center in September 1980 were \$201.50. (See: U.S. Veterans Administration, Department of Medicine and Surgery, Office of the Controller, "Summary of Medical Programs, September 1980," p. 55).

29. The Consolidated Memorandum of Receipt (CMR) of the VA Outpatient Clinic in Toledo, Ohio as adjusted, served as the basis in determining equipment costs.

30. In fiscal year 1980 alone veterans from Northwest Indiana accounted for over 14,000 medical staff visits to Medical District Seventeen Health Care facilities and another 6,000 fee visits. In addition, testimony rendered at the hearing before the House Veterans Affairs Subcommittee on Hospitals and Health Care on Nov. 30, 1981 in Gary, Indiana would tend to reinforce this belief.

31. The cost effectiveness of an outpatient clinic as a means to obviate hospitalization is most clearly reflected in comparing the costs of each. A visit to the model comprehensive satellite outpatient clinic would cost \$70.12 (Table 7). The per diem costs for hospital care at the Lakeside VA Medical Center in September 1980 were \$201.50. If the patient remained in the medical center the average 20 days the total episodic costs would have been \$4,030.00.

32. A variation on the theme of a free standing outpatient clinic providing either primary or comprehensive health care services would be to locate such a clinic within a community hospital. Such a proposed alternative location for a clinic was met with some skepticism when the implications in terms of required space were examined. A community hospital with any where from 35,000 to 55,000 square feet of clinically appropriate space readily available for lease is difficult to imagine. Placing a primary care or comprehensive satellite outpatient clinic, respectively, in a facility without adequate space would be akin to forcing it into a procrustean bed.

33. The purchase of ancillary laboratory and radiology support from a community hospital is an alternative, although not addressed in this study, to the provision of such services by the clinic itself. The VA Outpatient Clinic in Grand Rapids, Michigan is an example of this. On the one hand purchasing ancillary support would obviate the need to acquire some or even all radiology and laboratory equipment and a reduction in personnel costs by the number of staff necessary to operate it. However, the costs per test or procedure would almost surely be higher and lead to a greater cost per visit. Examined over time, the purchase of ancillary support may prove to be a less cost effective alternative. In addition, and perhaps most impor-

tantly, in the event that costs for purchased ancillary services become prohibitive and the decision is made to commence providing such services by the clinic for itself, the acquisition costs of the necessary equipment will have probably increased significantly and appropriate staff will have to be recruited. The net effect of such a scenario, resulting as it did from an earlier conviction that purchased services were a more cost-effective option, may be an even greater, and parenthetically unnecessary, expenditure of resources than initially required.

34. The data presented in Tables 9 and 10 reflect the resources and workloads of the three tertiary care facilities in Medical District Seventeen: VAH Hines, VAMC Lakeside and VAMC West Side. By virtue of mission and proximity, one of these three would be the parent facility for an outpatient clinic in Northwest Indiana.

35. Attachment D illustrates the extent of the resource deficiency experienced by Medical District Seventeen.

36. It is worth repeating that the impact which the activation of either a primary care or a comprehensive satellite outpatient clinic would have upon the community nursing home program in Medical District Seventeen has not been even broached. Consequently, whatever additional costs may arise in this program area are absent from any of the calculations made throughout the study.

37. Unanticipated costs to be absorbed in fiscal year 1982 by Medical District Seventeen include \$802,000 for GS salary increases, \$627,000 for the increased health benefits costs and \$1,426,000 for increase nursing salaries. (Source: District Coordinator, Medical District Seventeen, VAH Hines, IL).

38. Edgar, Robert W. and Hillis, Elwood, Members, U.S. House of Representatives, Committee on Veterans Affairs, Washington, D.C. Letter to Robert Nimmo, Administrator of Veterans Affairs, Veterans Administration, Washington, D.C., Dec. 9, 1981.

Question 2. I have seen estimates of \$6 to \$8 million as the activation costs for an outpatient clinic in Northwest Indiana, with recurring annual costs of \$2.3 to \$3.5 million. If the Congress earmarked this amount of money for an outpatient facility in Northwest Indiana, would you, as Administrator of Veterans Affairs, feel comfortable about the location of that facility if it did not mean the diminution of resources in your other health care facilities?

Answer. If the Congress made resources available for an outpatient clinic in Northwest Indiana, I would not feel comfortable about establishing this clinic. Much higher priority medical care programs are needed. The non-recurring cost for such a clinic is estimated at \$3.1 million, with additional recurring costs as high as \$12.0 million.

Question 3. I understand that an outpatient clinic is being activated this fall in Bradford, Pennsylvania, within an existing local hospital. Would you approve such an arrangement for an outpatient clinic in Northwest Indiana as an interim solution to improve the health care of these veterans? Do you believe such a plan would be feasible? If so, how long would it take before such a clinic could be activated in Northwest Indiana? If not, please distinguish between Bradford and Gary. I would also appreciate a copy of the feasibility study that was undertaken for the establishment of the Bradford clinic.

Answer. We are planning to activate a clinic in Bradford County, Pennsylvania, however I would not recommend a similar arrangement for northwest Indiana. Such a clinic would be feasible only at the expense of other higher priority medical care programs. Pursuant to your request the demographic study for Bradford County is attached.

A SATELLITE CLINIC FOR BRADFORD COUNTY, PA.

In 1973, a study was conducted by the Department of Medicine and Surgery to provide decision makers with a list of recommended locations for establishing VA satellite clinics. That study contained a list of 21 locations. A follow-up study was conducted in 1974 which contained a list of another 26 locations. The criteria used in the 1973 study required that the potential location must be an SMSA of 200,000 or more civilian population and at least 40 miles from an existing VA facility. The criteria for the 1974 study was relaxed to include SMSA's with a population of 150,000 or more people. SMSA's are standard metropolitan statistical areas which are metropolitan areas consisting of single concentrations of dense urban developments with strong internal commuting ties and weak ties to any other densely developed area. In 1979, another study was conducted which updated the information contained in the earlier studies and included any new ones for consideration as potential sites. That update added another 10 sites to the list of potential areas. Thus, a total of 57 potential sites have been identified for satellite clinics. The VA

has designated 21 locations for establishment of satellite outpatient clinics. All but 1 of them have been opened.

Bradford County, Pa. was not identified as a potential site in any of the studies conducted by the Department of Surgery because it failed to meet the basic criteria of being an SMSA with at least 150,000 people. The House Appropriations Committee, this year, has directed the VA to establish an outpatient clinic in Bradford County, Pa. as soon as possible. It was in response to this directive that DM&S conducted an analysis of the potential visits which a clinic in Bradford County could support. The analysis consisted of the following steps:

a. First, a theoretical service area was developed assuming a clinic was placed in Bradford County, Pa. The reasoning used for selecting counties for assignment to the theoretical service area was that veterans will tend to seek care at the clinic which is most accessible in terms of distance and/or travel time. A county was included in Bradford's theoretical service area if the distance from that county seat of government was closer to the potential clinic site than to any other VA health care facility. The following counties were assigned to Bradford, Pa.:

	Veterans population
New York State:	
Broome.....	31,520
Chemung.....	13,560
Delaware.....	5,120
Tioga.....	6,180
Pennsylvania State:	
Bradford.....	6,730
Cameron.....	1,050
Clinton.....	5,110
Elk.....	4,960
Lycoming.....	15,480
Potter.....	2,080
Susquehanna.....	4,410
Tioga.....	4,680
Total.....	100,880

b. The next step was to determine the estimated size of the veteran population for each of the counties in the theoretical service area. This estimated population is for 1985 and is shown above in the listing of the counties in the service area.

c. The third step consisted of assigning an appropriate visit rate, the rate of visits per thousand veteran population, to each county. The visit rates are based on the historical experience of existing free standings clinics (physically separated from a hospital) since they are considered most comparable to satellite clinics. The counties in Bradford's theoretical service area are listed below again. Also, shown is the distance from the county seat to the potential clinic, in mileage ranges, and the estimated visit rate per 1,000 veteran population based upon the historical experience as stated above.

	From	To Bradford (miles)	Visits per 1,000 veterans
New York:			
Broome County.....	25 to 49		190
Chemung.....	25 to 49		190
Delaware.....	75 to 99		103
Tioga.....	25 to 49		190
Pennsylvania:			
Bradford.....	0 to 24		435
Cameron.....	75 to 99		103
Clinton.....	75 to 99		103
Elk.....	100 to 124		123
Lycoming.....	25 to 49		190
Potter.....	75 to 99		103
Susquehanna.....	25 to 49		190
Tioga.....	25 to 49		190

d. The variables discussed so far were then combined to produce an estimate of the outpatient visits which a clinic at Bradford County could expect in its first full

year of operation. The visit rate was multiplied by the estimated veteran population for each county in the theoretical PSA and an estimate of visits calculated. The total visits for a satellite clinic in Bradford County are 19,300 based upon the above methodology.

Of the potential satellite clinic sites recommended in the 3 previous studies, i.e., 1973, 1974, and 1979, the closest area to Bradford County that is on the list of potential sites is Binghamton, N.Y. The visits estimated for a clinic if it were to be opened in Binghamton is also 19,300. This potential site was identified in the 1973 study. Of the counties identified for a theoretical service area for Bradford County, 3 had previously been assigned to the potential satellite clinic at Binghamton, N.Y. Those 3 are Broome, Tioga N.Y., and Susquehanna. The veteran population for these 3 counties totals 42,100 or approximately 42 percent of the veterans in the theoretical area for Bradford County. These counties also represent about 41 percent of the total visits expected for Bradford County if a clinic were to be placed at that location.

For information purposes, the following table displays the mileage from the counties in the theoretical service area to the nearest VA facility.

County	Nearest facility	
	Name	Road miles ¹
Broome.....	Syracuse.....	78
Chemung.....	Bath.....	38
Tioga.....	Syracuse.....	76
Delaware.....	Albany.....	85
Bradford.....	Bath.....	61
Cameron.....	Buffalo.....	135
Clinton.....	Altoona.....	72
Elk.....	Erie.....	98
Lycoming.....	Wilkes Barre.....	71
Potter.....	Buffalo.....	115
Susquehanna.....	Wilkes Barre.....	56
Tioga.....	Bath.....	50

¹ Approximate.

Question 4. Mr. Administrator, could you explain your rationale for the decision to employ a hospital administrator with no VA experience from a "for profit" corporation to act as the executive director of your revalidation steering committee? The VA has numerous outstanding hospital administrators with qualifications comparable to Dr. West. In the past it has been common practice to detail individuals for such tasks. Could you have not saved the Federal Government money by using one of the better qualified VA hospital administrators for this function?

Answer. Dr. West was selected for the following reasons:

(1) He brings an extremely wide diversity of experience to the VA because he has had 22 years of health executive experience in the largest medical center in the Southeastern United States; in two foreign countries; in general acute facilities; and in community and mental health hospitals. He also has city, county, town, federal, and private health executive experience.

(2) He has a proper academic background, is a fellow in the prestigious American College of Hospital Administrators, and is an accomplished author with many publications.

(3) He is a veteran of the USMC with an Honorable Discharge.

(4) He is internationally known and respected throughout the field of hospital administration.

Question 5. It is my recollection that an IG report on VA's domiciliary construction might result in total redesign of such construction. Would this mean that all domiciliary construction would slip a minimum of one year?

Please furnish for the record a copy of the Inspector General's report on this subject.

Answer. The IG report on the Domiciliary program recommended that a thorough consideration of the alternative of modernizing existing domiciliaries be considered prior to proceeding with new construction. At the same time, VA is assessing the overall domiciliary program in order to provide current direction for the future. The result of this assessment and a more intensive consideration of modernization poten-

tial will determine the future domiciliary construction plans. The IG's report follows:

VETERANS' ADMINISTRATION,
December 29, 1981.

To: Chief Medical Director.
Subject: Domiciliary program.

1. Attached is the Domiciliary Construction Program audit report. As presently planned, the program will provide for new construction of a 200-bed domiciliary in each of the Agency's twenty-eight medical districts plus renovation of some existing domiciliaries to provide an additional 900 upgraded beds. The total construction program will provide 6,500 domiciliary beds by the year 1993 at a cost in excess of \$400 million.

2. We have several concerns with the program: (i) the intended mission of the domiciliary program has not been defined, (ii) alternatives to new construction have not been adequately considered, (iii) space criteria used in developing new construction cost estimates appear excessive, and (iv) adequate consideration has not been given to the relocation of present domiciliary members and the use of existing facilities.

(i) *Domiciliary Mission.*—Should the doms be constructed to meet the initial and present program mission, i.e. provide housing for ambulatory aging veterans, or should the mission be broadened to enable the newly constructed doms to be converted to nursing home care units with only minor modifications? While the Agency has not established a formal mission statement, the first four dom locations completed under the present construction plan, at a cost of \$30 million, provided for full convertibility. The cost of constructing new, or renovating existing structures to meet the present mission statement would be substantially less than constructing new, fully convertible units.

(ii) *Alternative to New Construction.*—If the doms do not need to be converted to nursing home care units, our review determined that existing facilities can be renovated at substantially less cost than new construction. At the eight sites covered by our review, we estimate that savings of \$76.6 million could be realized against planned construction cost of \$120.0 million. In addition to cost savings, renovation alternatives would provide nearly 2,500 more beds than would be provided by new construction. Another alternative, not pursued in our review but worthy of serious consideration, would consider broader utilization, or sharing mission responsibility with state domiciliary programs. We understand that state program officials are actively seeking a greater role in domiciliary programs.

(iii) *Excessive Space Criteria.*—Draft criteria developed for estimating new domiciliary construction exceeds present criteria for VA and state domiciliary units and nursing home care units in terms of number of members per living units. In addition, our review disclosed that the four new domiciliary locations completed under the present plan have exceeded the draft criteria.

(iv) *Present Domiciliary Members and Existing Facilities.*—Existing facilities presently provide beds for nearly 8,400 domiciliary members. The present construction plan does not make provision for the nearly 1,900 members that will be displaced, nor does the \$400 million program cost reflect the cost of relocating members. As regards existing facilities, the new construction plan has not considered the cost and nature of recent, and planned future renovation in projecting facility demolitions. During fiscal years 1979 through 1981 nearly \$7.5 million has been expended in renovating domiciliary buildings. An additional \$5.6 million is planned for fiscal years 1982 and 1983. The present plan does not reflect that several of the Agency's domiciliaries are recorded as historical sites and cannot be destroyed. The buildings must be maintained either as active or unused facilities.

3. In view of the number and nature of concerns identified, and the substantial costs involved, we are recommending to the Administrator that a moratorium be placed on future construction plans until the mission of the domiciliary program is defined, and alternative solutions are developed and considered in meeting the defined mission.

4. We would like to consider the audit report as final. We believe that we have fairly presented the Department's position based upon our discussions. However, if you substantially disagree with our presentation of the Department's position, I would appreciate receiving your comments by January 11, 1982, in order to publish the report not later than January 14, 1982. If you or your staff have any questions or need further information please contact Mr. Bobby Oakley, Assistant Inspector General for Auditing, on extension 2259.

FRANK S. SATO, *Inspector General.*

REPORT OF AUDIT: DOMICILIARY CONSTRUCTION PROGRAM

SUMMARY

The Eastern Field Office of Audit conducted a review of the need for new VA domiciliary construction projects at VAMC's Bath, New York; Hampton, Virginia; Temple, Texas; Mountain Home, Tennessee; Prescott, Arizona; Leavenworth, Kansas; Hot Springs, South Dakota; and of the VA Domiciliary at White City, Oregon. The audits at the latter seven sites were conducted during February and March 1981. Plans for a new domiciliary at VAMC Bath, evaluated during an audit in August 1980, were updated in October 1981 and are included in this report.

The audit focused on the VA's plans for constructing new 200-bed domiciliary buildings in all 28 medical districts. Four of these buildings have already been completed. The domiciliaries visited during the audit are the next VA facilities scheduled for replacement domiciliary construction. The eight proposed domiciliaries reviewed have an estimated cost of \$120 million out of a total estimated program cost of \$400-500 million. As of December 1981, there were 16 existing domiciliaries with a total of 8,397 domiciliary beds. The agency has a goal of 6,500 beds by 1993; 5,600 to be provided through new construction and 900 through renovation of existing beds.

There were four principal audit findings: (1) The need for new domiciliary buildings has not been justified. Renovation of existing buildings could provide more beds and save approximately \$76.6 million. Also greater utilization of state veterans domiciliary programs should be pursued as an alternative. (2) The mission of the domiciliary program needs to be defined. New domiciliaries already constructed are fully convertible to Nursing Home Care Units (NHCUs), reflecting an upgrading of the present domiciliary mission to provide a higher and most costly level of care. (3) The space criteria for the new domiciliaries exceeds criteria approved for other VA health care modalities which escalates construction cost. (4) Demographic data was not used to justify the placement of veterans in new 200-bed buildings in 28 medical districts. Also, there are no plans for the disposition of veterans currently in domiciliaries whose numbers exceed the capacity of the smaller replacement buildings. A recommendation was made that the mission of the domiciliary program be clearly defined, that appropriate construction criteria be established and that construction plans for domiciliaries be reevaluated to insure all alternatives to new construction are considered.

The Chief Medical Director (CMD) responded to the audit by suspending new construction projects at Bath and Hampton pending clarification of the VA's mission regarding the domiciliary program. The CMD stated that he would concur with the audit findings if the mission of the domiciliary program is determined to be a protected residential program which does not provide for a major rehabilitation mission. If convertibility to NCHUs is needed he will not concur with renovation. He agrees that the draft space criteria should be reevaluated.

PART I. INTRODUCTION

A. Background

Derived from legislation in 1866 which established the Soldiers Homes for Disabled Veterans, the domiciliaries represent one of the original programs of the VA. Originally, the homes were converted barracks and there was little intent to provide medical care. During World War I, some medical services were provided and these were expanded through the 1920's and 1930's. Enactment of Public Law 293, in 1946, increased the emphasis on medical services with the establishment of the Department of Medicine and Surgery (DM&S). However, domiciliaries continued to serve essentially as protected residential programs. In 1962, DM&S established a domiciliary restoration-center program which had two goals: (1) returning the veterans to the community with employment and (2) placing the veterans in an independent living situation. The restoration-center program was terminated in 1972.

In 1974, DM&S established an ad hoc task group to determine the future of the domiciliaries. That task force recommended "redistributing the domiciliary program throughout the system based on population demand." At the same time, program officials began to define the role of the domiciliary as providing "necessary medical care, in a home-like setting" in contrast to the domiciliary's historical mission of providing a "home with medical assistance as needed." Existing VA Regulations (38 CFR 17.47) only require that domiciliary members be ambulatory and capable or self care.

In 1977 former President Carter directed that the agency should set a goal of 6,500 total domiciliary beds by 1993. DM&S developed plans to build 28 new 200-bed

units that would replace existing facilities and provide units for districts without a domiciliary. Also 900 beds at existing facilities would be modernized. Costs for the planned construction was originally projected at \$160 million but is currently estimated at \$400-\$500 million. Currently there are 16 domiciliaries having a total of 8,397 beds as of December 1981. All are located contiguous to a medical center except for White City, which is an independent domiciliary. Thus current plans reflect a drop of 1,900 beds by 1993.

Four new domiciliaries have been constructed under the program costing approximately \$30 million. These are located at VAMC's Wood, Wisconsin, Martinsburg, West Virginia, Dayton, Ohio, and Bay Pines, Florida. Each is fully convertible to a nursing home at additional cost. In 1979, the convertibility feature was dropped from new construction. However, the current construction criteria for domiciliaries continue to exceed criteria used for other VA treatment modalities.

In August 1980 during a cyclic audit of VAMC Bath, New York, the impending construction of a new 200-bed domiciliary building under this program was reviewed. Audit findings (included in this report) showed that renovation of existing facilities would provide the needed beds at considerably less cost than new construction and that the renovation alternative was not properly considered. A flash report was sent to the Chief Medical Director informing him of these findings. As a result construction plans were suspended pending further evaluation. An expanded audit of the construction program was considered necessary and is the subject of this report.

B. Scope

A centrally directed audit was conducted by the Eastern Field Office of Audit to review the domiciliary construction plans at the eight facilities. The purpose of the audit was to determine whether new construction was necessary to provide the required domiciliary beds at each of the individual sites and whether alternatives to new construction were properly considered. The audit efforts included extensive preparation in VA Central Office (VACO), which included interviews with DM&S Extended Care Service, Facilities Planning, Facilities Management and Office of Construction. A detailed review of plans, proposals, VACO reports and correspondence was made regarding the proposed construction.

The planned construction was reviewed onsite with appropriate management and engineering staff at the audit site. The engineering staff assisted the audit team by providing data showing the cost of renovation needed to upgrade existing facilities to meet acceptable standards for personal privacy and safety.

The examination was made in accordance with the GAO Standards of Audit of Governmental Organizations, Programs, Activities and Functions and included such tests of the procedures and accounting records as we considered necessary under the circumstances.

The audit began January 5, 1981 and was completed on November 18, 1981.

PART II. RESULTS OF AUDIT

A. Findings and recommendations

The audit showed a lack of justification of need and failure to fully consider lower cost alternatives to new construction at the eight sites visited. Existing domiciliary structures are sound and will allow for renovation at considerably lower costs. Because most buildings are historically significant and will be retained, the cost of their maintenance would continue, thus duplicating such costs in the replacement domiciliaries. Another alternative not considered is greater utilization of state domiciliary facilities. The audit also showed there is a need to clearly define the mission of the domiciliary program. The four domiciliaries completed under the program to date are fully convertible to NHCUs at increased construction cost. Moreover, the draft space criteria currently being used in domiciliary construction plans exceeds criteria for existing health care modalities and will continue to escalate costs. In addition, the present plan to build essentially equal sized domiciliaries in all 28 medical districts does not appear to consider the demographics of the veteran population and will also result in shifting of currently domiciled veterans.

Recommendation

The mission of the domiciliary program be clearly defined in the context of whether or not it is to remain substantially a protected residential program.

Based upon the decision regarding the mission of the program, clear, appropriate, construction criteria need to be established and adopted.

Construction plans for all domiciliaries be reevaluated to insure that all alternatives, including the use of state facilities, are considered.

Discussion

Audits at eight domiciliary construction sites found a lack of justified need for new construction and a failure to fully consider lower-cost alternatives such as the renovation of existing facilities. The VA should not proceed with any additional new construction until the most cost effective means of providing suitable facilities are identified. Audit results show that renovation of existing facilities is a viable and considerably less costly alternative to new construction.

Adequate justification for the new construction projects at the eight sites was found to be lacking. In five of six cases requiring an Advance Planning Fund Study, no study was made. In the one case where a study had been conducted it was limited in scope and did not consider the feasibility of renovation as an alternative to new construction. It was also unclear why the new domiciliaries were initially being built at locations which already had domiciliaries, predominately in historical buildings which are not to be demolished. At these sites, the replacement domiciliary would not absorb the existing populations and as a result there may be a need to maintain some of the existing buildings as domiciliaries (Exhibit 1). This will further escalate costs.

There is a need for the VA to accurately determine the number of beds which will be required to provide appropriate facilities for its domiciliary population. A study by the Department of Medicine and Surgery reported in April 1975 that the number of veterans needing domiciliary care would be 10,000 by the 1990's.

Currently there are 8,379 beds, and, although there is a planned reduction to 6,500 beds by 1993, specific plans on how the VA will meet the needs of the remaining veterans after the bed reductions have not been developed (Exhibit 1). Furthermore, no demographic study was conducted to justify the proposed allocation of one 200-bed domiciliary for each medical district. In addition to the 8,379 existing domiciliary beds, the VA currently has contracts with the states to place veterans in state domiciliary homes. There are presently 40 domiciliaries in the State Home Program with a total authorized bed level of 7,469. The census for the Veterans in state home domiciliaries as of July 31, 1981, was 4,613 for an occupancy rate of 61.8 percent. Under the State Home Program the VA reimburses all states a flat rate of \$6.35 per patient day as long as the state's per diem costs is at least \$12.70. The VA also provides up to 65 percent of original construction costs, renovation costs and structural additions to state homes. The alternative of greater utilization of state facilities was not considered as an alternative to new construction.

At the eight facilities audited, we found that little or no consideration had been given to the future use of the historical domiciliary buildings which exist at six of the sites. These facilities are structurally sound and would continue to be maintained in any case at additional cost. Regarding domiciliaries at Mountain Home and White City, additional major construction was found to be unnecessary for the foreseeable future. These two facilities had already upgraded more than 200 beds each to meet contemporary standards of occupancy. Moreover, for the eight sites visited, nearly \$7.5 million has been expended in renovating existing domiciliary buildings during Fiscal Years 1979-1981 and an additional \$5.6 million is planned for Fiscal Years 1982-1983 (Exhibit 2). Also, we found that no plans have been made for the dispersion or other disposition of the veterans who are to be displaced by bed reductions at the domiciliaries visited. There was a consensus among management officials at the sites that a 200-bed domiciliary would not fulfill the needs of the medical districts. At Temple, Texas, the Director had already requested an increase in domiciliary beds from the planned 200 to 400. There should have been a sound basis such as a demographic study to establish the appropriate distribution of domiciliary beds throughout the country. There is no available data that would support an equal dispersion of the domiciliary population among the 28 medical districts such as planned.

We also found a need to reevaluate the space criteria developed for the proposed new domiciliaries. In the absence of VA-approved space criteria for domiciliaries, we used the criteria which were locally acceptable and which have been incorporated into recent construction projects of these facilities. Although the VA had developed draft space criteria for the new domiciliary buildings, these criteria exceed the approved criteria for other health care modalities and escalate the costs of new construction (Exhibit 3). These new criteria are still unapproved, although the latest version has existed since October 1980. Prior to April 1979, the criteria allowed for convertibility of domiciliaries into nursing home care units. The four domiciliaries already constructed under the program contain the expensive convertibility feature. This feature has been dropped from current plans. The audit findings show that considerable cost savings can be achieved through renovation regardless of the criteria applied. At VAMC Bath we used the new DM&S draft criteria as the basis of our

evaluation since these criteria were being used by station management personnel. However, for other facilities we used criteria compatible with recently funded renovation projects (e.g., VAMC Hampton and White City), because such criteria were already being applied in major domiciliary renovations at these sites. The criteria which were used during the audit were considered by the VA facilities' staff to be appropriate for local needs.

Estimates of renovation costs were considerably less than projected costs of new construction at the sites visited. At the eight sites visited during the audit, we estimated that cost savings of \$76.6 million could be realized by renovating existing facilities instead of new construction. Considerably larger savings will result if it is decided that extensive renovations are not needed to provide veterans with the same environmental provisions as hospital inpatients and nursing home care patients. Upgrading domiciliaries to meet or exceed health care facility standards that are reflected in the draft criteria is questionable based on the historical mission of domiciliaries; providing a home for aging, ambulatory veterans with incidental medical services as needed. If there is a change in the program's mission, this should be formally accomplished by appropriate legal and procedural means, and should be supported by professional determination of need. In the meantime, new construction should not be necessary when there are feasible, less costly alternatives available such as renovation or use of the existing state facilities. Results of reviews made at the eight sites visited are discussed below.

VAMC Bath, N.Y.

The new 208-bed facility is estimated to cost approximately \$10.8 million. During the audit VAMC Bath's Engineering Service prepared an estimate for renovating existing domiciliary buildings, using DM&S and Office of Construction draft criteria. In determining renovation costs, Engineering Service included redesign and construction improvements to accomplish the removal of architectural barriers, elimination of safety and fire hazards, compliance with SERP and OSHA requirements, as well as improving energy conservation potentials for these buildings. The total estimated cost to renovate two buildings and provide 210 beds is \$5.6 million. The total estimated cost to renovate all five domiciliary buildings is approximately \$11.5 million for providing 395 domiciliary beds at a cost which is only \$700,000 (6 percent) higher than the cost of the proposed new 200-bed domiciliary building alone. The cost per bed for renovation of 210 beds is \$26,488 and for 395 beds \$29,195. This compares to cost per bed for new construction of 208 beds of \$51,923 (Exhibit No. 4). A flash report was forwarded to the CMD by the IG on September 2, 1980, due to the planned award of the contract in September 1980. As a result the contract award has been delayed pending resolution of the need for new construction.

VAMC Hampton, Va.

Alternatives to building the new \$10.8 million domiciliary have not been pursued. No VA Central Office studies were conducted to review the feasibility of renovating the existing domiciliary. The medical center's Engineering Service staff provided the auditors with an estimate of the total costs to renovate the existing domiciliary buildings. The engineering estimate used a rate for extensive renovation of \$60 per square foot, which would allow the domiciliary to meet standards of occupancy, fire safety and privacy currently being used for ongoing renovation projects. The cost data provided by VAMC Hampton's Engineering Service indicates that renovation of all current buildings would be more economical than building a new, smaller domiciliary. Renovation of all five of the buildings would provide for 472 beds at an estimated cost of \$9.9 million. More significantly, a renovation of only three of the current buildings at a cost of approximately \$5.2 million would provide for 240 beds. The cost per bed for the 472 bed renovation is \$21,159 and for the 240 beds renovation \$21,817. This compares to cost per bed for new construction of \$54,000 (Exhibit No. 5). The buildings that presently house domiciliary patients are historically significant, and will likely not be demolished. Use of these six buildings for other purposes is limited due to a lack of alternative need for them by the medical facility. Due to the planned awarding of the construction contract in June 1981, a Flash Report was forwarded to the CMD by the IG on August 19, 1981. As a result, construction has been delayed pending resolution of the need for new construction.

VAMC Leavenworth, Kans.

Agency plans call for a new 5-story high rise domiciliary building with four floors containing 52 beds each, and a ground floor for administrative offices and support facilities. No studies have been performed to consider alternatives to this plan. There are also no plans for existing domiciliary buildings, e.g., how they will be utilized, whether they will be demolished, or if they will be converted to other use. A

renovation estimate for all domiciliary buildings was prepared by the engineering staff. The renovation was intended to correct fire and safety deficiencies and provide for necessary nonrecurring maintenance. If the five largest existing buildings (buildings 4, 8, 10, and 14) were renovated, the cost would be approximately \$4.5 million. The five buildings would contain 240 beds. This cost is considerably lower than the \$10.4 million projected for a new 200-bed domiciliary. Renovation of all existing space at an estimated cost of \$9.9 million would provide for 775 beds.

VAMC Prescott, Ariz.

Future plans call for a new 200-bed facility to be constructed in Fiscal Year 1985 at a cost of \$10.8 million. There is, however, no evidence in the Advance Planning Fund (APF) study conducted here in January 1980 that the VA took into consideration the option of renovating existing domiciliary buildings. No other studies were performed to compare the feasibility of new construction versus renovation of existing domiciliary buildings. Facility engineering staff provided the auditors with a cost estimate for upgrading existing domiciliary buildings. Engineering service estimates included relocation of two clinical services from the domiciliary buildings and would provide space for a total of 190 beds, at a cost of \$5.2 million. There is a strong likelihood that VAMC Prescott will retain the current domiciliary buildings which are historically significant, even if a new 200-bed facility is completed. Should this occur, additional maintenance and resource costs will be incurred beyond the cost of the new domiciliary.

VAMC Hot Springs, S. Dak.

Future plans call for a replacement domiciliary with 200 beds at an estimated cost of \$27 million. However, the medical center engineering staff, using the draft space criteria, estimated that 340 beds could be accommodated within the present buildings. Total renovation of the buildings was estimated to cost \$6.7 million. Renovating only a part of the space to accommodate a 200-bed domiciliary would cost less than \$4 million. Because of the historical significance and the good structural condition of the existing domiciliary buildings, there is a strong possibility that the present buildings will continue to be maintained whether a new domiciliary building is constructed or not. This would likely result in additional costs.

VAMC Mountain Home, Tenn.

Future plans call for construction of a new 208-bed domiciliary in 1985 at a cost of \$13.7 million. However, no VA study has reviewed the feasibility of utilizing the existing domiciliary buildings rather than constructing a new domiciliary. Building renovation which has been recently completed, or is planned for the existing domiciliary buildings, should provide suitable facilities for all current domiciliary members at VAMC Mountain Home. For example, buildings 2, 3 and 5 have all had privacy partitions put in, bathrooms have been remodeled, and the interiors have been upgraded. Renovation is now in progress for building 2, which has 56 beds out of service because a new floor is being put in. There are no plans for the demolition of any of the current buildings at the domiciliary, and since they are historically significant it would be difficult to do so. As part of a facility initiated 25-Year "Master Plan", a technical evaluation of the facilities at VAMC Mountain Home was performed by a private firm in December 1980. All domiciliary buildings were included in that evaluation. All onsite inspection confirmed that, despite their age, the current domiciliary buildings are in structurally good condition. Provided they are properly maintained, these buildings are judged to be structurally serviceable throughout the contemplated 25-Year Master Plan through the year 2005. If a new domiciliary is built the current buildings would likely be retained and there would incur additional costs.

Olin E. Teague Veterans Center, Temple, Tex.

DM&S plans call for constructing a new 200-bed facility in 1984 at a cost of \$11.5 million. However, no study was performed to compare the feasibility and the cost of renovating existing buildings instead of new construction. Engineering Service staff estimated that renovation of all existing domiciliary buildings would allow for 528 beds and include renovation of interiors for improved patient privacy. In 1972, three of the domiciliary buildings were fully renovated. If there is a need to renovate only 275 beds in the present domiciliary, this would reduce the projected total cost to approximately \$4 million.

Department comment

The Chief Medical Director (CMD) responded to the draft report by memorandum dated October 9, 1981. A meeting was held on November 12, 1981, between the

CMD, the Inspector General and support staff to discuss the Department of Medicine and Surgery's position. The CMD stated that new construction projects at VAMC's Bath and Hampton, would not commence until there was a clarification of the VA's mission regarding the domiciliary program. The CMD indicated he would concur with the audit findings, if the domiciliary program is interpreted to be a protected residential program and not provide for a major rehabilitation mission. He emphasized two necessary courses of action needed before additional construction is undertaken:

a. There is a need for a study of the practicality and cost effectiveness of renovation of existing buildings compared to new construction costs.

b. There is a need to reevaluate the draft space criteria being used for new domiciliaries.

However, the CMD also stated that he does not concur with the renovation alternative if the domiciliary program includes the convertibility of domiciliaries to nursing home care units.

Office of Audit comment

There is inadequate justification for new domiciliary construction and no additional new projects are warranted at this time. The feasibility of developing alternatives to construction such as renovation of existing facilities; the need for approval of realistic space criteria; and the clarification of the program mission should be resolved to ensure that program economy is emphasized in the plans for domiciliary facilities. We have requested that we be advised of these program decisions prior to proceeding with additional new construction.

EXHIBIT 1.—VA DOMICILIARY OPERATING DATA (1981)

	Operating beds	Bed occupancy	Average monthly turnover	Per diem	Projected bed level 1993	Change
Existing locations:						
Bath, N.Y. ¹	525	89.9	4.7	\$30.68	208	-317
Biloxi, Miss	430	93.7	6.9	28.61	325	-105
Bonham, Tex	225	90.7	7.6	22.53	(*)	
Dublin, Ga	344	89.5	5.7	31.23	250	-94
Hampton, Va. ¹	603	83.6	6.5	29.27	250	-353
Hot Springs, S. Dak. ¹	475	80.2	9.2	30.39	200	-275
Leavenworth, Kans. ¹	719	90.1	13.1	19.23	260	-459
Los Angeles, Calif	400	81.0	7.5	22.25	350	-50
Mountain Home, Tenn. ¹	611	93.8	9.2	28.49	250	-361
Prescott, Ariz. ¹	226	81.4	8.7	33.40	200	-26
Temple, Tex. ¹	528	82.2	11.4	28.21	* 328	-425
White City, Oreg. ¹	1,040	85.4	7.6	29.35	208	-832
New domiciliaries:						
Bay Pines, Fla	201	86.1	10.6	46.75	200	-1
Dayton, Ohio	790	88.9	5.7	40.54	250	-540
Martinsburg, W. Va	541	92.1	5.7	33.06	200	-341
Wood, Wis	739	89.9	5.3	37.81	200	-539
Total	8,379	87.7	7.7	* 31.48	3,679	-4,718
New locations					2,821	+2,821
Total locations	8,379	87.7	7.7		6,500	-1,897

¹ Sites visited by Inspector General.

* Bonham, Temple combined.

* Average new \$39.54/average old \$27.80.

EXHIBIT 2.—SUMMARY FOR DOMICILIARY RENOVATION COSTS

(Numbered in thousands)

	Past fiscal years 1979-81	Projected fiscal years 1982-83
Mountain Home, Tenn	\$607	\$837
Leavenworth, Kans	531	722
Hot Springs, S. Dak	947	207

EXHIBIT 2.—SUMMARY FOR DOMICILIARY RENOVATION COSTS—Continued

(Numbered in thousands)

	Past fiscal years 1979-81	Projected fiscal years 1982-83
White City, Oreg.....	4,193	¹ 2,275
Prescott, Ariz.....	186	² 47
Temple, Tex.....	95	(¹)
Hampton, Va.....	506	1,542
Bath, N.Y.....	483	(¹)
Total.....	7,548	5,630

¹ Indefinite: waiting decision on new domiciliary construction.² 1 Year (fiscal year 1982) projection only.

EXHIBIT 3.—SPACE CRITERIA COMPARISON

	Domiciliary (draft criteria)	Nursing home care unit	Spinal cord injury unit	State home
Percentage of beds:				
1-bed room.....	12	10	10	
2-bed rooms.....	75	70	20	
4-bed rooms.....	12	20	70	
8-bed rooms.....				100
Multiple living unit (MLU).....	1			
Residents per bath.....	1.8	5.0	2.0	8.0
Other provisions (separate from medical center):				
Kitchenettes.....	(¹)	(¹)	(¹)	(¹)
Recreation facilities.....	(¹)	(¹)	(¹)	(¹)
Dining facilities.....	(¹)	(¹)	(¹)	(¹)
Arts and crafts.....	(¹)	(²)	(²)	(²)
Patient lounge.....	(¹)	(¹)	(¹)	(¹)
Quiet room.....	(¹)	(¹)	(²)	(¹)

¹ Yes.² No.

EXHIBIT 4.—VAMC BATH, N.Y.—CRITERIA/COST COMPARISON

	Draft criteria	New construction O/C plans pending	210-bed renovation OIG	395-bed renovation OIG
1-bed room (percent).....	12	12	12	12
2-bed rooms (percent).....	76	88	88	88
4-bed rooms (percent).....	12			
Residents per bath.....	1.8	4	4	4
Apartments (MLU).....	2	2	2	4
Cost (1981 dollar).....		\$10,800,000	\$5,562,500	\$11,532,000
Number beds.....		208	210	395
Dollar cost per bed.....		\$51,923	\$26,488	\$29,195

EXHIBIT 5.—VAMC HAMPTON, VA.—CRITERIA/COST COMPARISON

	Draft criteria	New construction O/C plans pending	240-bed renovation OIG	472-bed renovation OIG
1-bed room (percent).....	12	12	5	5
2-bed rooms (percent).....	76	88	15	15
4-bed rooms (percent).....	12		80	80
Residents per bath.....	1.8	1.8	8	8

EXHIBIT 5.—VAMC HAMPTON, VA.—CRITERIA/COST COMPARISON—Continued

	Draft criteria	New construction O/C plans pending	240-bed renovation OIG	472-bed renovation OIG
Apartment (MLU)	2	8	0	0
Dining hall	4,100	¹ 4,100	² 5,000	² 5,000
Cost (1981 dollar)		\$10,800,000	\$5,236,000	\$9,987,000
Number beds		200	240	472
Dollar cost per bed		\$54,000	\$21,817	\$21,159

¹ New square feet.² Existing square feet.